

**HEALTH CARE FOR CHILDREN:
PROTECTING AMERICA'S FUTURE**

INT Files

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED
OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FIRST CONGRESS
SECOND SESSION

—
LANSING, MI
MAY 30, 1990
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CONTENTS

OPENING STATEMENT

	Page
Riegle, Hon. Donald W., Jr., a U.S. Senator from Michigan, chairman of the subcommittee	1

COMMITTEE PRESS RELEASE

Finance Subcommittee to Hold Field Hearing on Health Care for Children; Improving Access to Health Care Services to be Focus.....	1
---	---

PUBLIC WITNESSES

Rosebush, Chris and Brian, Burton MI	5
Redden, Irma, Dearborn, MI.....	7
Dyke, Debbie, Monroe, MI.....	10
Wiener, Raj, director, Department of Public Health, Lansing, MI.....	14
Ashby, Sue, director of marketing, Muskegon General Hospital, Muskegon, MI.....	17
Lincoln, Valerie, R.N., service line director for women and children's health, Northern Michigan Hospitals, Petoskey, MI.....	20
Rozek, Tom, president and chief executive officer, Children's Hospital of Michigan, Detroit, MI.....	24
Brenner, Sheldon, director of ambulatory pediatrics, Children's Hospital of Michigan, Detroit, MI.....	27
McKinney, Marvin, Ph.D., director of planning and community affairs, Mott Children's Health Center; board member and representative of Michigan Maternal and Child Health Council, Flint, MI.....	30

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

Ashby, Sue:	
Testimony	17
Prepared statement	37
Brenner, Sheldon:	
Testimony	27
Dyke, Debbie:	
Testimony	10
Prepared statement	39
Lincoln, Valerie:	
Testimony	20
Prepared statement	40
McKinney, Marvin:	
Testimony	30
Prepared statement	43
Redden, Irma:	
Testimony	7
Prepared statement	46
Riegle, Hon. Donald W., Jr.	
Opening statement.....	1
Prepared statement with attachments.....	47
Rosebush, Chris and Brian:	
Testimony	5
Prepared statement	52

IV

	Page
Rozek, Tom:	
Testimony	24
Prepared statement	53
Wiener, Raj:	
Testimony	14

COMMUNICATIONS

Responses to a request for comments by Senator Riegler	56
--	----

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

WEDNESDAY, MAY 30, 1990

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Lansing, MI.

The hearing was convened, pursuant to notice, at 2:10 p.m., in Prudden Hall, Lansing Civic Arena, 505 West Allegan, Lansing, MI, Hon. Donald W. Riegle (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press Release No. H-32, May 8, 1990]

FINANCE SUBCOMMITTEE TO HOLD FIELD HEARING ON HEALTH CARE FOR CHILDREN; IMPROVING ACCESS TO HEALTH CARE SERVICES TO BE FOCUS

WASHINGTON, DC.—Senator Donald W. Riegle, Jr., (D., Michigan), Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, announced Tuesday that the Subcommittee will hold a field hearing in Michigan on problems faced by children who lack health insurance.

The hearing will be on *Wednesday, May 30, 1990 at 2 p.m.* at Prudden Hall, Lansing Civic Arena, 505 West Allegan, Lansing, Michigan.

"As a nation, we must provide adequate and affordable health care for our children. It's a national tragedy that over 12 million children have no health insurance, 300,000 in Michigan alone," Riegle said.

"I am holding this hearing to bring attention to the problems of children who face difficulties in getting needed health care. Health care for all children is an essential part of an on-going effort in the Senate to provide health care for all Americans," Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. Let me welcome all of you in attendance today. I appreciate your being here. I want to especially thank our witnesses who are here today. We have a flu bug moving around that has hit some of our children who were planning to be here. My daughter, Ashley, who is five, had the problem a couple of days ago. So I am very familiar with that particular situation. But I am delighted that we have our witnesses today and they have brought us very important testimony.

Let me indicate to all in attendance that today is an official hearing of the Senate Finance Committee, Subcommittee on Health for Families and the Uninsured. Today the focus of our hearing is on the problems of our most vulnerable citizens, namely

our children—and the problems that they face in obtaining health care in Michigan and in our country.

I think it is truly a national tragedy that over 12 million children in America today, and close to 300,000 of them that live here in Michigan, have absolutely no health insurance whatsoever—not a penny of coverage.

We will hear testimony from families with children today who do not have health insurance and also from providers and advocates that are desperately trying to meet the needs of uninsured children in Michigan.

I want to welcome anybody else that has a statement that they want to make that is not a scheduled witness today to give us that statement, either in writing or orally. We will have the staff take it down in the course of the afternoon, because I want to include it as part of the formal committee record. All of the testimony that we receive today, whether given orally by witnesses or in writing or in a statement by anyone in attendance or submitted to us, will be included in the official transcript of the hearing.

Now, this hearing is entitled, "Health Care for Children: Protecting America's Future." We picked that title for a very good reason. Recent trends tell us a very disturbing story about how we as a nation are caring for our children. While the United States has the most advanced and sophisticated health care system in the world on the one hand, on the other hand we find that one in five children in our country does not have any health insurance. The many faces of these uninsured children, as we will hear today, raise important questions about our current health care system and how it is working.

I am going to ask Debbie Chang, if she would, to stand up just for a minute. I want to show you a couple of charts that we have prepared here. I am just going to have her motion to parts of the chart as we describe them.

The first chart shows that 41 percent of our uninsured children, about 5 million, live in families with incomes below the Federal poverty level. So we have a substantial number of kids in that category, but it is significant that that is less than half of the total number. So clearly our Nation's public program, Medicaid, is an inadequate safety net for low-income children, covering only about 50 percent of children below the poverty level.

But many of the uninsured children actually live in what we would think of as middle income families at the same time. So we have a situation where in many cases you have a family where people—one or two members of the family—are working, but there is no health protection available for children through the work site or it is just too expensive in many cases to be purchased privately, and in other cases the insurance companies just will not even take the cases because of the preexisting problems that exist.

Let me go quickly to chart 2 here. Many children are also falling through large cracks in our employment base system of health care. Three-fourths of uninsured children live in working families. In these cases, the employer does not provide insurance or else as I have said the family cannot afford to purchase it. Other children have no access to care because they have a preexisting medical con-

dition and are actually excluded from coverage because the insurance companies will not insure them.

So you have this terrible anomaly, where the kids that most need the protection and the coverage are the ones that are told that they cannot have it, that they are uninsurable.

The impact of this lack of adequate care is reflected in key health indicators. The United States continues to have one of the worst infant mortality rates with 18 other industrialized countries having fewer babies die in their societies than we do here in the United States. This is particularly alarming since these deaths are preventable.

We know that prenatal care is one of the most cost effective ways to spend health care dollars and yet one in three pregnant mothers receive inadequate prenatal health care. And, of course, the failure to get early prenatal care often means that a child is born, very often underweight or with other difficulties or born prematurely. Then, this can bring with it other problems and enormous expenses, often born directly by the public to try to deal with these tiny children who in many cases have severe problems that could have been prevented with adequate prenatal care.

So, overall the United States has far to go. But some regions face even greater problems. In Michigan, although the infant mortality rate of almost 11 deaths per live births is consistent with the national average, Detroit's rate at the present time is over 20, or almost twice the rate of the Nation as a whole. And, in my own home County of Genesee County, we have a rate close to 15, even though there are extraordinary medical resources there to try and help save these tiny babies when they come in underweight and prematurely with problems.

So, however you measure it, our children are simply not getting the care they need and they deserve. For example, millions of children fail to receive routine immunizations against preventable disease, such as polio, measles, and mumps. This is very costly to our society in both human and economic terms. We know, for example, that \$1 spent on immunization saves \$10 in future health care costs. So, by investing the \$1 we know that we can save \$9. The small amount of up front cost actually saves us money as we go down the track.

And frankly, not only do we not have the lives to waste, we really do not have the money to waste either with this kind of inefficiency in our health care coverage system where millions of children do not have the most simple health care protection.

Now, just to bring this home to Michigan, we have already experienced 220 reported measles cases already this year in our State and we have had one death here in the State of Michigan. And this is a disease we now are able to prevent, but not if the children are not getting the inoculations they need.

The Senate has just passed an emergency appropriations bill, and we put in that bill \$35 million for immunizations. We expect that to be signed into law soon. But more can be and must be done in that area.

Let me just quickly summarize a few other points. I do this to lay the foundation for our hearing where different witnesses through-

out the public testimony will be adding the specifics from their own vantage points.

We have a problem in the rural areas where a lack of providers of health care is a key problem. Many providers also chose not to participate in Medicaid because of the administrative difficulties and because of the low-reimbursement rates. The complicated enrollment process itself is a barrier for people needing health care. We also have inadequate outreach programs to bring families into our health care system. So our current system clearly needs to be reformed.

I think the needs of our children ought to initially be our primary focus and then we can move on from that to the health problems of people of all ages.

I want to say too that as chairman of this subcommittee, I have introduced legislation to continue work that we started last year to improve health care coverage for low-income pregnant women and children. The Medicaid Child Health Act includes over 15 provisions that expand Medicaid eligibility and improve benefits and delivery of health care services.

I am also working at the present time to increase funding for the Maternal and Child Health Services block grant by a figure of \$125 million. Believe me, these are bargain rates and we get back more than its cost in terms of the savings later on down the line for more serious health problems.

I want to say in addition to the initiatives for children that a bipartisan group, 15 Senators now, is drafting a comprehensive national health care program that will provide health insurance by one means or another to every single person in our society—that is all 240 million, regardless of age.

Because while our focus today is on our young people and on our children, the problems of lack of health insurance affect people of all ages in every situation, and it is time to change that. It is time to fix that in America. We can afford to do it and there are ways to do it in rearranging our health care system, getting more efficiency out of it, where I think we can actually pay for the broader coverage with savings in terms of a more efficient health care system.

And significantly, just recently the physicians of the United States themselves came forward and said that it was time to have a comprehensive health insurance program available to everybody in the country—not just to some, but to everybody in the country. We will be having these physicians testify on behalf of that position before the Senate committee in Washington quite soon.

So just to conclude, if our children are going to have a full chance for a good and a productive life, they need to be healthy. America's children clearly represent our future and we need to protect that future. So high quality, affordable health care for all Americans is one of my top priorities in the Congress. I know you share that feeling and that is what brings all of you here together today.

Let me now go ahead and introduce our first panel and thank them again for appearing here. I am going to introduce the panel and then—give you the introductions for all three—and then we will go through each one, one by one, as they give their testimony.

Our first panel consists of three Michigan families whose children lack health insurance coverage. They will discuss the difficulties that they face in obtaining affordable health care services for their children. Their personal stories and testimonies will underscore the critical problem facing our children and our families who do not have access to health care.

First, we are going to be hearing from Chris and Brian Rosebush and their two children, Aaron and Sara. They are from Burton, MI. Chris and both of the children have diabetes. The Rosebushes are a working family whose employer provides no health insurance. Though they have coverage for their children's diabetic condition, their other basic health needs essentially have to go unmet. Their case illustrates how fragmented and complicated the current health care system can be. I will call on them in just a moment.

Our next citizen witness will be Irma Redden, who is a single parent from Dearborn, MI. Her son Eddie has Cerebral Palsy. Though she has coverage from her employer, she has not been able to obtain health insurance for her son, Eddie, due to his preexisting medical condition. That is the terminology that is used to deny health insurance coverage to the people who need it the most. So, it is very important that we hear from her about exactly how that works.

And then finally we are going to be hearing from Debbie Dyke, who is here from Monroe, MI. Ms. Dyke is currently unemployed and receives Medicaid for herself and her two daughters, Melissa and Mindy. Last year Ms. Dyke was employed but in the job she had she received no health benefits and because she was working she lost her Medicaid coverage. Ms. Dyke will testify to the dilemma of families who receive no employer-based health benefits and who cannot afford private health insurance themselves, and do not otherwise qualify for Federal or State assistance.

These three illustrations will tell us a great deal about this and help us lay out the committee record that we will need to get legislation enacted.

Chris, I think if you are ready, we will start with you. I know Brian may come back in. I know what it is like to have a child that needs to be taken out for a minute. But we are delighted to have you. Why don't you speak right into the microphone and let us hear from you now.

[The prepared statement of Senator Riegle appears in the appendix.]

STATEMENT OF CHRIS AND BRIAN ROSEBUSH, BURTON, MI

Mrs. ROSEBUSH. My name is Chris Rosebush. I am here today with my husband, Brian and my two children. Aaron is 5 years old and Sara is 2. The children and I are all insulin dependent diabetics, so good medical care has always been a necessity. But unlike most American families, we are not able to go to the doctor or hospital whenever we think it is needed. Because unlike most other American families, we have no health insurance.

At one time we didn't have to worry about having health insurance for our family. My husband, Brian, had Blue Cross at his place of work. He was employed there for 6 years and during that

time, Blue Cross paid for my children's birth and their stay in ICU afterwards. There were a few times when Aaron and Sara had to be hospitalized during infancy, but knowing we were covered by insurance took some of the strain off me and my husband.

But 3 years ago Brian lost his job. Our Blue Cross was gone as well. Luckily, the children were able to qualify for the State's Crippled Children's Program. however, this covers only expenses for Aaron and Sara's diabetes, nothing else.

Brian has found another job working full time as a waiter. We thought we would receive hospitalization coverage after 1 year but they ended up not offering health benefits. I have tried to buy coverage from other health insurance companies but the premiums were much too high for our family. Companies wanted over \$700 every 3 months. Even if we could afford that kind of payment, when companies find out we have diabetes, they don't want to cover us.

I've also applied for assistance from the Michigan Department of Social Services. We were finally told that the children qualify for Medicaid coverage, but only after we spend about \$1,600 per month out of our own pocket. But we certainly cannot afford to spend \$1,600 per month in medical bills for the children. So the only way we could benefit from Medicaid coverage is if one of the children has to be hospitalized and the bill costs over \$1,600. Then Medicaid could help, but we'd still be responsible for the \$1,600 per month.

In the meantime, we must pay for all our health care out of our own pocket. My son, Aaron, had to have minor surgery on his mouth not long after my husband lost his job. We still had Blue Cross but our coverage was about to end. The oral surgeon wanted \$200 up front. My parents were there to help loan us the money. We thought everything was fine until after the surgery the doctor wanted more money. With no job and a little bit of unemployment coming in for my husband, we were not able to pay. The doctor turned us in to a collection agency. Our total now in medical bills is over \$1,000. That doesn't count the money we pay for the walk-in clinics either.

I, myself, have been a diabetic since I was 6 months old. But it has been years since I've been to the doctor for care. I just got the flu so bad that I needed a doctor. I got turned down at offices because I have no insurance, so my father took me to his doctor. The doctor told me I should be hospitalized, but with no health insurance he did the best he could do. Everyday I worry that the same thing will happen with Aaron and Sara.

My husband is looking for a different job with health insurance. He was recently in the final 10 for a factory job. It had excellent health benefits, but he didn't get the job. So he continues to look and we continue to worry that if Aaron or Sara get sick we might have no place to go for health care.

I have looked so hard to find help for my children and to be turned down has put a terrible strain on my husband and me. We fear one of us will need a hospital and be turned down. Our children need the best of care but our money isn't enough. We know we're not alone and that many others are in the same situation. We need to band together and stand up to be heard.

Senator RIEGLE. Thank you for such a powerful statement. Let's let her know how we feel about her coming here. [Applause.]

It is very difficult, I think, to come and lay out all of these personal facts; and it takes great courage to do that. I want to say to you, Chris, and to Brian how much we admire and appreciate your being here today, and also being the kinds of parents that you are and how you love your children and are trying in every way you can to help your children.

I think of your children as "our children," as America's children. So to the extent they are not getting the care that they need, the hardship that falls on you really is stealing something from our future as a nation. As we sit in this room and look at Aaron there, he is as precious as any child in America today. We have to think of him that way, just as we do your daughter as well.

And that is how we have to shift the focus around in America. It is not that we do not have the resources to solve this problem. We clearly do. We are spending more on health care in the United States as a percentage of gross national product than any nation in the world. We are spending about 12 percent. The next highest nation is only spending about 8 percent. So we are spending a fortune on health care.

The problem is that only some get it; and others, like little tykes that you are seeing here at this table today, have none at all in America of the 1990's. We cannot allow that to continue. I think there is a moral imperative that makes it clear that it must be changed. But it is also more than decency; it is good solid, national thinking. It is the way countries think about how they build themselves and make themselves strong for the future, and that is by taking care of their people. And if they do not take care of their people then no nation over time is going to be able to have the kind of a future that it might otherwise envision for itself.

So I want to thank you for really a wonderful statement and a very powerful statement. When your husband comes back in, if at any point he wants to add something, we would be delighted to hear from him as well.

Mrs. ROSEBUSH. Thank you.

[The prepared statement of Mrs. Rosebush appears in the appendix.]

Senator RIEGLE. Irma, we are very pleased to have you here. As I said earlier, your son, Eddie, has a problem with Cerebral Palsy and you have not been able to obtain health insurance for him because of the fact that the insurance companies view this as a "pre-existing medication condition." So we very much appreciate your being here. We would like you now to share your story with us as well.

STATEMENT OF IRMA REDDEN, DEARBORN, MI

Ms. REDDEN. My name is Irma Redden and I am a single parent currently employed with a small trucking company in Dearborn. I am here today to testify about the problems I have had in obtaining health insurance for my son, Eddie.

When Eddie was 2 years old, he was diagnosed as having Cerebral Palsy, which is commonly referred to as CP, and a learning

disability. CP is a disabling condition that causes loss of control over voluntary muscles. Eddie looks like a normal 4-year-old boy, however, he actually functions like a two and a half year old. Children with CP often fall because of their poor muscle coordination. Therefore, I worry about him when he plays because there is always a chance he could get hurt.

Like any concerned parent, I want to get my son covered for insurance. I realize the cost of prescription drugs or a visit to the doctor or an emergency room visit would be astronomical. That is why in August 1989 I asked my employer to help me get insurance benefits. He agreed and took quotes from John Alder Insurance Co. The agent representing the company assured me that Eddie and I would both be covered under their Preferred Provider Organization of Michigan. He gave me the personal enrollment form and asked me to fill it out.

The personal enrollment form asked for many details including a health history of Eddie and me. One of the questions asked was if either of us had been treated for or told that we had a physical disorder or deformity. I answered yes and explained the particulars of Eddie's condition on the reverse side. I also explained that Crippled Children's Program, which is a State organization which provides financial assistance to families of children who have handicapped conditions, they pick up any extra expenses related to Eddie's CP. When I say extra expenses, I mean his therapy, orthopedic doctors and his neurologist.

The next month I received a letter from the insurance company stating that I had been approved for health benefits and that Eddie had been denied due to the fact I admitted he had CP. When I heard this news, I was extremely upset and contacted their underwriting department to find out more about Eddie's denial. I was told that if I had been employed by a larger company, then Eddie's health history probably would have slipped through and he would have received coverage.

I was very irritated because they didn't pay any attention to Eddie's actual medical history to find out that he is a healthy child, not prone to accidents or illnesses, or to the fact that Crippled Children's picks up all the extra expenses related to his disability. If they had explored his case a little further, I feel we may have received fairer treatment.

At this point I was totally frustrated and contacted my caseworker at Crippled Children to explain the problem. She referred me to the United Cerebral Palsy Foundation. I had contacted them in the hopes that they would be able to provide me with some assistance. I soon found out I was not the first person who contacted them with this problem. Apparently, several parents with handicapped children are faced with the same difficulty of finding health insurance.

Because these cases are based on discrimination, the Foundation is thinking of filing a law suit. However, at this time, they could only promise to contact me if they ever decided to do so and provide me with further information. even though I was upset about not going to battle with the insurance company, I was relieved to know that there are people aware of the problem and I remain hopeful that 1 day the system will be changed.

My next step was to contact a social worker at the Henry Ford Foundation who eventually led me to you. We were trying to see if Eddie would be eligible for the Supplemental Security Income, a program of last resort for people who need cash assistance and health care benefits. Unfortunately, I received a denial from them which stated that because of my income Eddie did not meet the eligibility requirements. However, if Eddie ever feel down and broke his arm, I could take him in for emergency treatment. This would be a one-time visit only and no follow-up visits would be covered.

So currently Eddie remains uninsured. I have received quotes from other insurance companies but they are much more than I could ever afford. Furthermore, I have been told that even if I could pay for it, I would be denied due to Eddie's condition.

I only make enough money to make ends meet. At this time, my salary doesn't allow me to save for unforeseen expenses. So when Eddie needs to go to the doctor it comes right out of the money we use for our groceries or daily living costs. For example, last year Eddie had an ear infection and needed to be seen by a doctor. The office call was \$25 and the antibiotic was another \$25. Because I paid for the visit that same day, I didn't have enough money to pay for our phone bill and it was disconnected. In addition, we had to use part of our grocery money for the balance of the bill.

In closing, I want to say that I am upset that I cannot insure my son. I want to be able to take care of him when he gets sick or injured. I want to have the kind of insurance policy or income that would enable me to seek treatment for Eddie without having to spend the money that should be used for our groceries or other living expenses. I will never neglect his need for medical treatment. However, I live in fear that some day something will happen to Eddie and I won't be able to take care of him.

Thank you for allowing me to testify.

[The prepared statement of Ms. Redden appears in the appendix.]

Senator RIEGLE. Thank you for coming to testify. [Applause.]

Thank you for sharing your story with us. It is obvious that Eddie is lucky to have you for a mother. And I know you feel lucky to have him for a son; and it is important that you be able to feel proud of us as a country because we recognize the needs that you are dealing with and respond to them.

We should, I believe, be responding to every situation like this in the country. No family should be in this kind of state of terrible anxiety and not having access to care and the knowledge that they can get the help they need at a time when a medical crisis strikes. There is no fear that I know that is worse than that of a parent when you have a sick child. There are lots of aches and pains and agonies that we all experience through our life times. But for my money, and from talking with many other people, that is the one that most people find hardest to deal with.

I think what you are doing, like Chris who has spoken before you, is really making a heroic effort in the face of a system that is just wrong. It is just flat wrong. The fact that we can have an insurance system and the insurance system says yes to the person that maybe doesn't need it and no to the person that desperately needs it is a system that needs to change. And if it cannot be

changed sufficiently within the private sector arrangements, then that is what we have a country for.

We have a country to make sure that our people are in a situation where their health and their well-being is protected. That is why we ban together. That is why we form a country in the first place, is to make sure that we have a situation where our citizens have the opportunity to live decently and to live properly.

So I want to say to you and make a pledge to you that we are going to get a universal health care insurance system in place. I am not going to rest until we get it done and there are others that feel as I do. Unfortunately, there have not been enough at the Federal level, but the number is growing and the awareness is growing in very large part because people like yourselves are willing to come forward and tell your stories.

I am going to take this information that I am getting today in this hearing and I am going to share it with all the members of the Senate, so that they all have an opportunity to understand what is going on, what is actually happening to real life people and to children each hour of each day who are in this situation of a lack of coverage and the terrible anxiety that goes with it. So we will get this job done with your help.

So I have to ask you to hang in there and as difficult as it may be for now, do not lose strength and do not lose hope. Because we are, with the help of a lot of other people like those in the room today who are here as moral supporters in the position that you are advancing, we are going to get this done. We are just going to get it done and we are going to get it done in time for Eddie. So have some confidence in that.

Let me now turn to Debbie Dyke, who as I said earlier is from Monroe, MI. Debbie is currently unemployed. She receives Medicaid for herself and her two daughters, one of whom is with her now. Last year, she was employed but received no health benefits. And because she was working she lost her Medicaid coverage. This is, again, one of the very perverse ways in which the system works improperly—that is, if you are in a situation where you are eligible for Medicaid you can get coverage for family members, whereas if you then find a job in the private sector that does not provide insurance for your family members, you end up having the job and having the income, but losing the health care protection.

We have changed that in the law now with respect to disabled persons. We have just accomplished that in last year in Washington. I am determined to accomplish that with respect to this situation where people need Medicaid and find employment and yet are unable to have health insurance coverage for their children. So, we intend to remedy that situation.

Debbie, I appreciate your coming today. I would like you to pull the mike nice and close to you and we would like to hear from you now. Tell us about you and your children.

STATEMENT OF DEBBIE DYKE, MONROE, MI

Ms. DYKE. I am here today to tell of the dilemma I found myself in a few months ago. My name is Debbie. I have two daughters, Melissa, age 14, and Mindy, age 10.

Like most other Americans I always had every hope of getting a job and supporting my family. After my divorce some years ago I became eligible for assistance from the Aid for Families with Dependent Children Program. But in 1988 the State started a program called "Job Club." It was designed to help Department of Social Services clients find full-time work. I was in this program for 6 months when I landed my full-time job in May 1989. I worked 40 hours a week and made \$5 an hour. I was really happy and felt good about my independence.

The only problem was, I had no health benefits. I was told when I took the job that my employer was going to offer medical insurance. He never did. At the same time, my DSS caseworker informed me that as of November 30, 1989, my children and I no longer would be eligible for Medicaid because my new income made me ineligible.

Finding yourself without health care coverage is upsetting for most families. But for my family the situation was more than upsetting, it was frightening. My oldest daughter, Melissa, has severe bronchial asthma. She is on three different medications daily to keep her asthma under control. She has two inhalers she uses four times daily. Her Proventil inhaler runs \$19 and her Intal inhaler runs \$25. Her inhalers last only 2 weeks. She also takes Proventil pills three times a day which run about \$20 a month. Melissa also takes Predisone when she has a real bad spell.

After our Medicaid card expired last fall, we were really in trouble. I was making about \$180 per week. After paying rent, utilities, gas to get to my new job, food, and other essential living expenses, there was not much left for these medical bills. Just where am I supposed to go to get the money to pay for these medical costs? And these are just the expenses that I know I will certainly have. What happens when Melissa or my other daughter gets sick, falls and breaks a leg, or worse yet, needs an operation? Where do people like me and my daughters go for help?

We were constantly worrying about where the money for Melissa's next inhaler would come from. The school nurse would call me at work to tell me that Melissa couldn't breathe. I would have to talk with her over the phone or go to the school. Melissa and I would end up arguing about how often she could use her inhalers. How are you supposed to tell your daughter that she must use her medication less because her mother doesn't make enough money to buy her what she needs. The school even ended up buying her an inhaler to keep with her during classes. My grandmother Mudge also helped out when she bought Melissa two inhalers for Christmas.

The nurse at school called Social Services to tell them of her condition and that she needed to have the inhalers to breathe when she had a spell. But they could not help since my \$5 an hour salary prohibited us from qualifying for the program.

My other daughter, Mindy, got a severe sore throat last winter when we were without insurance. I wanted to take her to the doctor for an antibiotic when it didn't clear up in a couple of days. I couldn't, however, because I didn't have the money to pay for the office visit.

From December 1989 to February 1990, I spent over \$150 on prescriptions alone. You see, I also have asthma and need prescriptions to keep my condition under control. When you're making less than \$200 per week, you don't have to do a lot of figuring to know that it is next to impossible to make ends meet.

I kept asking my employer to please get health coverage for the employees. The company recently made some changes and I was laid off. I believe that if I had not continued nagging my employer for these additional benefits, they would have been willing to train me for additional job responsibilities.

As of right now, I do have Medicaid back for my children and myself since I am drawing unemployment benefits. Because we have good access to health care through Medicaid, Melissa no longer gets upset when her inhaler starts running low.

I honestly do not know what people in my situation are supposed to do. I want to work and support my family. I very much enjoyed working and earning my own way. But when having that job ends up penalizing my children by denying them needed and costly care, what am I supposed to do? My employer did not offer benefits, I did not make enough money to buy private coverage, and the State had to cut me and my children off Medicaid because I made too much money.

We have to do something about this problem of health care for our children. As for me, I will do what I have to in order to keep my children healthy, happy and safe. If that means staying on AFDC in order to keep Medicaid for my children, I will do that. Until something changes or I can find a job with health benefits, I cannot justify putting my family through an ordeal like that again. After all, my daughters' health is much more important than my pride. [Applause.]

[The prepared statement of Debbie Dyke appears in the appendix.]

Senator RIEGLE. You deliver such a powerful statement, like the other two witnesses that have spoken before you. I want to say to you as well how much I admire your courage and your strength in what you are doing as a mother. When I try to stop and think what there is in this country that is more important for us to spend money on than an inhaler for Melissa, I have a very hard time thinking of anything that is more important.

We spend money on lots and lots of things, and lots of it is wasted, whether it is in the military budget which is very bloated or whether it is in other parts of the Federal budget or other budgets we have. But if we have a youngster, whether we know them or not, whether they are in our family or somebody else's family, that is having difficulty breathing and they need an inhaler, you know, this country in 1990 ought to be able to see to it that kids that are in that situation have an inhaler.

I mean we just have to do that. And there should not be even any debate about it. I mean that debate—we ought to be able to have and settle that debate in 1 day—and get on with solving the problem.

I am struck also by the fact that it is clear from what you say that you want to work, that you do not want to be on AFDC. And in fact, it hurts your pride, as you yourself said in the last sen-

tence, to in effect have to be on welfare for the purpose of making sure you have health protection for two daughters who like yourself have an asthmatic condition and therefore need to have that care just to protect their very lives.

So the whole country is cheated in that situation. I mean you are cheated out of having a job. The country does not have the gain that you could offer to it by being able to work, which you want to do and which you were doing. And also if we persist in the current pattern, we would have a situation where if you were working then your children are at risk healthwise that I think is very damaging and threatening to the country.

So, we often wonder what the face of America is. I think we have just seen the face of America in these three stories, and the children that are here, and those who are represented but who cannot be here today, Eddie included. I think it is very important that those of us who are in this room and are within the range of this experience need to take these facts and take this kind of information and take it out of this room and take it throughout our communities and throughout our State to reach people and help people understand that this is a problem that we must solve and we must solve it now. It is a problem that can happen in any family.

There are a lot of families today that may well have health insurance because they are in a situation where they have got a job that provides family coverage. That can be gone tomorrow. That can be gone next week. The major unions in the country have come in to visit me. Lane Kirkland, head of the AFL-CIO, testified the other day before a major Budget Committee hearing, and said the major problem facing organized labor today is the elimination or the reduction in negotiated health care plans.

So that even people who have had health care at the work place are finding that it is being eaten away, and in many cases taken away, either the family members are shaved off or eventually health care through the work place disappears altogether.

We must see, as a society, the importance of having a health care system in place that does not depend upon where you work. We need basic health insurance coverage that is universal, that cuts across the society and picks up everybody so that no child is laying out there sick at night with a desperately worried parent not knowing what they should do and being afraid to take that child to the doctor or to the hospital because they cannot pay the bills or because they are going to be turned away when they get there because they do not have money in their pocket.

We do not have to settle for that in America now. That is something that can be changed, but we have to insist on change and we cannot allow the people who say, well we cannot change it or there is this reason or that reason. It is a lot of baloney. It can be changed and it is time to change it. These are the reasons to change it, because there are people who cannot wait. They need the help now and that is why we have a country and why we have a government, to organize ourselves to do what is necessary to help our people.

This should come right up at the top of the list. Because if you are not well and healthy, and if your children are not well and healthy you cannot do much else. So let's agree on the fact that

that is going to be something that if you hold those views you are going to do something about spreading it broadly and widely, because we need to get a broad public consensus building up that can help us move this legislation.

Let me say to each of you—I know you may have other things that you want to do—you are certainly welcome to stay at this point and listen to the other witnesses. I want you to feel as well that if you need to excuse yourselves that you are free to do so and leave at any time. I want you to feel flexible and comfortable about going or staying as you will because I want to go on to our other witnesses now.

But again, let me thank all three of you and thank your family members for the support that they have given you. Let's give them all again our thanks. [Applause.]

Let me say, Melissa, to you and to Aaron, that we are very proud of you too. We think you are great. So we are going to give you a round of applause too. [Applause.]

Let me now move to our other witnesses who are here. I want to say how especially pleased I am that Raj Weiner is with us today. She serves importantly as the director of Michigan's Department of Public Health and really gives great leadership in that position. I have had the occasion to see that on numerous occasions from the work that we must do together between the State and local levels.

She is going to testify today from her vantage point on what she sees and the important relationship of Federal programs to the State as well as a variety of State initiatives that are in place and that are being put in place to try to deal with some of these problems that we are facing.

Clearly, this is a problem that is national in scope. It is going on in each and every State and the response in very substantial measure has to be a national response. That is why this is a Federal hearing of the Finance Committee to look at this thing from the national perspective. But the leadership that we are getting from States that are moving in a progressive way to try to fill in these gaps is very important and I am very pleased that she is with us.

We would be pleased to hear your testimony now.

STATEMENT OF RAJ WIENER, DIRECTOR, DEPARTMENT OF PUBLIC HEALTH, LANSING, MI

Ms. WIENER. Thank you, Mr. Chairman. And thank you for the opportunity to share a few perspectives from the State of Michigan.

I would like to talk about three issues. The first is access to health care for children. The second is the desperately needed expansion in the maternal and child health block grant that you have sponsored and supported. And the third is immunization for all of our children.

When you look at all of the cuts that we are facing, whether it is in State or Federal Government, as we try desperately to keep our case load up of pregnant women on WIC and give babies who are born, and who are poor a healthy start in life, it makes us wonder if there is anybody paying attention to the need of our children.

Today, Senator Riegle, I want to thank you for your commitment, your continued support. There are times when we wonder if

anyone hears our voice. It is good to know that you do hear it and you are here today to listen to us and also to cause there to be action in Washington.

I want to talk first about access. I do not want to spend a lot of time quoting studies and statistics that document the problem. I think they have been done very well. They have been done in a way that no responsible society can turn their back on. Lack of access to health care is a problem that has been a rising concern for some time. It did not happen overnight and it is not going to go away overnight. I want you to know that here in Michigan Governor Blanchard's task force on access to care showed that there were 990,000 persons, almost 1 million, who do not have any insurance or are underinsured; and that 30 percent of them, or 300,000 of them are children.

When you listen to the nightmares that we heard today from the Rosebushes and from the Reddens and from the Dykes, the children that they brought here, the three children that they spoke about, multiply that by 100,000 because there are 300,000 such cases here in Michigan. That is nothing that we can turn our back on.

I can also tell you that we expect that the problem will get worse. It will get worse because health care costs are rising at an uncontrollable rate. More and more employers are going to be cutting benefits, benefits for dependents. We're moving from a manufacturing into the service oriented economy. So the problem truly is going to get worse.

We all know that we spend an awful lot of money on the administrative costs of creating a health care system—one that rations health care according to whether or not we are eligible in some criteria, one that rations health care according to whether our employer provides us with some basic coverage of health care. And all of these "eligibilities" create a very complex system that costs a great deal of money that could be better used if removed from the system and used for assuring adequate basic access to care for all people.

We have all heard the arguments backwards and forwards about why we cannot move to a national universal health care plan for everyone in this country right now or in any particular State. But the point I want to make to you today is that we had better start with our kids. Having outlined these problems and knowing the complexity of the problems that it has caused, just these three families here and the 300,000 others that are not in this room, we had better at least start with some form of national health plan for our children.

I want to tell you about two very excellent programs here in Michigan. One, it is called "Healthy Start." It has been proposed by Governor Blanchard to remove all of these barriers that you heard about for children up to the age of 10 years old. So that just by the virtue of the fact that they happen to be a resident citizen of the State of Michigan they can get coverage; and it is an expansion of the Medicaid coverage that is offered today which is very comprehensive in this State.

We are having a very hard time getting that program approved through the legislature. Just yesterday, for the second time, the

Senate voted no on Healthy Start. The total cost of that program is only \$13 million for the first year.

It is one of the reasons we want to come forward and support the bill that you have introduced, Senator Riegler—that is Senate bill 2459—because if that were passed, it would cut our States cost by 50 percent, to only \$7 million. It would mean that every child in this State who lived in a family of up to 200 percent of poverty—that means for a family of four, around \$24,000 a year in income, would be eligible to get the care that they needed. They would not have to shop around. They wouldn't have to make a choice between health and groceries; or a choice between seeing the doctor and buying the antibiotic.

We need Federal support to get a program like Healthy Start launched here in Michigan. No matter what program we try to create here in this State we really cannot do it alone. The complexity of the health care system is such that it should not be done on a state-by-state basis.

We hope that with Federal movement on Senate bill 2459 it will also encourage the Senate here in Michigan and the legislature to support Healthy Start. It has a companion program which is called the Sentinel Network System which is designed to reach the high-risk children in our State.

We see the facts all around, in our infant mortality rate and in the school dropout rate. You heard today about Michigan's Crippled Children Program. We have a \$14 million expenditure in that program over and above what we anticipated. It is an indication that more and more children are being born with their health compromised. The Sentinel Network System is one that offers support services at home for the child born at risk, and it involves the coordination of all of the State agencies.

Here is a program that is eligible for Federal funding today. Once again, we are having a hard time convincing our legislature. But I think with movement of Senate bill 2459 we could get more of that support.

The second issue I want to talk about is the Maternal and Child program. We desperately need an increase in the Federal block grant, because with that increase it would mean that when a woman came in to get prenatal care—whether it was in Monroe or Burton, Detroit or Flint—they wouldn't be turned away because we'd have had to reduce our caseload because we no longer had the money. We are now at our financial limit. We have spent the last 3 years in Michigan expanding our support system for pregnant women, to give them prenatal care.

That complex Medicaid form you have talked about, we have reduced ours from 28 pages down to 2 pages. We have created an extensive outreach for pregnant women to get prenatal care in Michigan regardless of ability to pay. But if we do not get that increase in the maternal and child block grant we are going to be turning these women away after having created the system that they need to help them produce healthy babies.

Finally, I want to talk about immunization. It was the Michigan delegation that got involved and took the lead to pass a \$35 million increase for immunization. I had an opportunity to meet with your office, Senator, and members of the Michigan delegation earlier

this year. We need that money. We still have an epidemic ongoing in our State. I understand the bill is on the President's desk. I hope the bill will be signed very soon and I want to thank you for your support.

Senator RIEGLE. Thank you very much for your comments and for your presentation. It is much appreciated. You have given us important testimony and I appreciate the leadership and the emphasis you put on moving in on this problem of children in our society with no access to health care. I want to also acknowledge that Patrick Babcock, who is the Director at the Department of Social Services has also arrived and is responsible for Medicaid in Michigan, is in the back of the room.

Let us give both Raj and Patrick a round of applause for their leadership in this direction. [Applause.]

I know some of you will have to go at different points, and so I don't want anybody to feel like they are pinned in their chairs. We have a very good turnout here. We have over 135 people in the audience.

I want to acknowledge also the two individuals who are signing for us—Mr. Max Basil, who you see now, and who we much appreciate for his help; and Michele McCoy, who has also assisted us other times. We are very grateful for their help.

I want to now introduce the next two persons who will speak to us and make presentations—that is Sue Ashby, who is the Director of marketing for Muskegon General Hospital. She will discuss the problems with our current health care system; and she will describe how her hospital manages the health care needs and the costs of uninsured families. With her, testifying separately, is Valerie Lincoln, who is the service line director for women and children's health for Northern Michigan Hospital in Petoskey. She will outline the special problems of providing health care services to uninsured children and families in rural areas.

I am just going to take the two of you next and then we will take our remaining witnesses. So, Sue, we are pleased to have you and we would like to hear from you now.

STATEMENT OF SUE ASHBY, DIRECTOR OF MARKETING, MUSKEGON GENERAL HOSPITAL, MUSKEGON, MI

Ms. ASHBY. Thank you, Senator Riegle. I am very pleased to be here and to have this opportunity to address some of the problems that we see in Muskegon, which certainly are no different than any other community in Michigan or in any other State in this Union.

I would like to present a brief overview of some of the problems that we do see in Muskegon and how Muskegon General Hospital has designed approaches to deal with some of these problems. We feel that we have come up with the beginnings of some solutions.

One of the problems that we see in a very extensive manner in Muskegon County is that we have many people who are eligible for health care services but do not have access to those services. Medicaid. Many individuals are covered for health care benefits through this program but still are unable to receive the medical services which they need. Physicians, and indeed hospitals, limit the

number of Medicaid patients that they see. They state that they do this because of reimbursement.

Obviously most hospitals, and certainly the ones in Muskegon County, never refuse treatment to anyone in the case of an emergency. But there is some selection as far as payer mix. It is an unpopular subject to mention, but that is a fact that we are dealing with in our society today. Families covered—

Senator RIEGLE. Let me just stop you, Ms. Ashby, and ask you to explain that to us. I appreciate your laying it out there because what we want to do is we want an unvarnished view of what is happening so that we can really understand the dynamics and then devise a response to the problems.

Ms. ASHBY. Payer mix you mean?

Senator RIEGLE. Could you just take a minute and elaborate on both?

Ms. ASHBY. Hospitals have to be financially solvent in order to continue to provide the full range of services that we do. In Michigan recently there has been a lawsuit that was withheld. It was called the "Bell decision," whereby the Michigan Hospital Association sued the State of Michigan for inadequate reimbursement to hospitals. In fact, hospitals get about 73 cents for every dollar of service that we provide.

Obviously, regardless of our commitment to provide services to people on Medicaid, it places us at extreme risk to continue doing so at a loss. It is really that simple. We have to continue to have adequate reimbursement in order to be able to provide the full range of services that we offer our communities.

Senator RIEGLE. I should say to you that related to that, the one piece of legislation that we are hoping to get enacted this year and where I am leading that particular effort, addressed this question of reimbursement rates on Medicaid to try to get more money to the States, particularly for children. These funds would help solve some of that problem, not necessarily all of it but it would be an important step.

I wish there was a light switch at the back of the room that we could all run to and flick that switch and we would solve the entire problem at once. We would be in a race to see who could get to the light switch. But we are coming with an approach here that we think will help you in that area. We very much hope to get that accomplished this year. I just say that as an aside.

Ms. ASHBY. Well the problems didn't happen all at once and the solutions will not either.

Families covered under Medicaid do have difficulty accessing health services. Without preventive and primary care many children and their families suffer more serious health problems and complications than they would have had they been able to access services early.

In our emergency department we see approximately 16,000 patients a year and a full 25 percent of those are situations that should be treated in a primary health care setting—a family practitioner's office. But these people do not have family practitioners because they are not accepting Medicaid or they in fact do not have any health care services.

This presents another problem in that a person will be seen in the Emergency Department by a panel physician. But that panel physician will not necessarily provide follow-up care. So it presents another complication.

The working uninsured. The issues related to that have been already attested to today so I will not go into that. One thing that is very important though, for all of us to keep in mind, is that the cost of providing health care is a cost problem to our communities. It is a State problem; it is a Federal problem; and it is a local problem, because those funds have to come from some place and they are seen in the rising costs of health care insurance premiums that local businesses pay.

Muskegon General Hospital runs three programs that are that are unique to the problems that we just addressed, and I would like to touch on those. First of all, the Family Health Center began providing services last summer. This is a family practice physician residency training program. We serve individuals who are covered by Medicaid, Medicare and/or private insurers.

Patients are not denied services due to any kind of insurance or their inability to pay. A full range of family practice health services are offered from prenatal to pediatrics to geriatrics. This has been a unique way in approaching health care for our citizens in our community and at the same time provide medical training for our resident physicians.

The second program that we offer is the OB High Risk Clinic. This also is operated in conjunction with our OB/GYN residency training program and in cooperation with the Muskegon County Health Department. The infant mortality rate in Muskegon County has decreased dramatically since Muskegon General Hospital has been working with the Health Department on this clinic. The infant mortality rate in 1986 was 10.7 per 1,000; in 1988, the latest year for which figures are available, it had decreased to 7.0 per 1,000.

We know that this is a direct result of the work that we do through our OB residency training program and our Health Department. The positive effect of the OB High Risk Clinic extends beyond the infant mortality rate, however. Women who participate receive training in infant and child care and they are introduced to many community resources which have the potential to reduce or eliminate further health problems for their children.

The third program is also a new one, which we have initiated, and is called "Recovery Care." It is a sub-acute substance abuse program that is licensed to take Medicaid eligible individuals. Needless to say, since we opened this program we have been at capacity and have had a waiting list.

It is a sad fact that in 1989 around 50 women in Muskegon County presented themselves at Emergency Departments for the delivery of their infants and stated that they had had no prenatal care. Many of these women were suspected of or had a history of drug abuse and many of their infants showed signs of fetal distress.

Chemically dependent women are served in our Recovery Care Program and in our OB High Risk Clinic. Through the increased awareness of the problems of pregnancy and chemical addiction,

the hazardous effects on the children of these women will be addressed.

In addition, Muskegon General Hospital has a commitment as part of our physician recruitment and practice guarantee program that our physicians will accept Medicaid patients. That is something which is a strong commitment that we have and is clearly communicated to the physicians who locate in our community.

Muskegon General Hospital is committed to providing needed services to people in the community and also to containing the high costs of health care. The programs previously described have had a significant and major impact on the health of children, women and men in Muskegon County. We hope adequate reimbursement will continue and can increase so that we will be able to continue providing these very important services.

Thank you.

[The prepared statement of Ms. Ashby appears in the appendix.]

Senator RIEGLE. Thank you very much, Sue. Let me say how impressed I am with what you have told us about the programs that you have initiated there and the way you are running them. Is there enough experience yet to see how you are doing financially? Are you holding your own? I mean you have obviously branched out to try to do more and to do it in a more comprehensive way. How is the financial struggle going?

Ms. ASHBY. We are doing all right financially with these programs because of the way the programs have been designed; and then obviously by utilizing resident physicians in training. There recently has been some legislation coming through the Office of Substance Abuse on the State level that would eliminate funding for residential drug abuse treatment. We are quite concerned about that because it is going to do no good to put a person through 2 days of detoxification and back on the streets.

Senator RIEGLE. Right, especially with an infant child to care for.

Ms. ASHBY. That is correct.

Senator RIEGLE. Valerie, we are very pleased that you are here and why don't we pass that microphone over to you; and we would be pleased to hear your statement at this time.

STATEMENT OF VALERIE LINCOLN, R.N., SERVICE LINE DIRECTOR FOR WOMEN AND CHILDREN'S HEALTH, NORTHERN MICHIGAN HOSPITALS, PETOSKEY, MI

Ms. LINCOLN. I am here to share a quick vignette which represents the issues that are very different than the previous witnesses, those through the eyes of rural northern Michigan. I do so wearing many hats. I am the service line director for women and children's health at Northern Michigan Hospitals in Petoskey. Prior to this I was the regional prenatal coordinator and most of my activities were dedicated to outreach activities. I am also the chair-elect of the Michigan Coalition of Healthy Mothers/Healthy Babies for this State; a mother of two; and a nurse whose mission in life has been advocacy for women and children's health issues.

As the saying goes, "You are who you hang around with," and I have been very fortunate to have been associated with many individuals of vision who have done good work on behalf of cases like

we have heard this morning. This mission of mine is very frustrating in that I unfortunately live in a society which has valued military initiatives over human services. Your comments are well taken about maternal child health grants and why we need more.

I also live in a society that singularly has not valued our heritage or our legacy, which are our women and our children. I am often reminded of the caricature that came out of an Eastern newspaper in response to the maternal child health grant blocks being chopped with the Federal Government being the pirate ship and women and children were first off the plank.

I also live in a society which for the noblest of reasons has embraced the notion that we are all created equal and are entitled to the best that health care can deliver. This notion is filled with deceit and prejudice, however subliminal or overt. I am afraid I live in a society which until the priorities on a national level reflect humanism and not militarism is buckling under those pressures at hand, particularly in rural northern Michigan.

I see diversification as a major problem. We have tried to divide the spoils, so to speak, on unsuspecting shoulders like hospitals, taxpayers, bureaucracies, and medical professionals. Maternal child health has long operated under the philosophy of "let's rob Peter to pay Paul." The result has been in our State, as Ms. Wiener has relayed, cannibalization of maternal child health programs, "are we going to be able to have immunizations or are we going to be able to render prenatal care?" And somebody always loses. Is it Public Health that is going to lose this time or is it DSS? And it is the same family. We have eliminated any kind of holism, as you have indicated, as a nation in order to alleviate those problems.

But let me further clarify my world which is not resource rich, as my predecessor has shared. The world of rural health in northern Michigan, categorically has major problems associated with: access to care, geographical maldistribution of human resources—what few human resources we have—inadequate services, little public transportation in a vast geographic area, a population disproportionately poor and poorly educated who are trying to survive in these economically challenging times.

I live in a world of vast contrasts, however. The haves and the have nots which I see as germane to this whole issue. My family lives in a community which is the recreational haven for the super wealthy of this country. They are in contrast to the pockets of frankly impoverished northern Michigan folks who either live there because they always have, or because they relate to the spirit of the north country, or because they are indigenous people of the Chippewa and Ottawa tribes.

Our reality mirrors the haunting figures that you have already shared with us. However, specifically, 40 percent of our children are impoverished—it is our distinct reality.

Senator RIEGLE. Forty percent of the northern Michigan populations in the area where you are?

Ms. LINCOLN. That is correct, in our catchment area.

Eighty percent of this catchment area income is less than \$25,000.

Senator RIEGLE. Would you please say it again. Eighty percent—

Ms. LINCOLN. Of our attachment area—

Senator RIEGLE. Yes.

Ms. LINCOLN [continuing]. Has income less than \$25,000.

Senator RIEGLE. That is family income?

Ms. LINCOLN. That is correct.

If one corrects, however, for the affluent areas that I am very familiar with—like Charleroi or Petoskey, it geometrically increases. Thirty-three percent have no high school education. An inordinate percent are seasonally and sporadically employed in the service industry as Ms. Wiener indicated, barely able to keep their heads above water, let alone have any kind of health insurance.

It is not that we don't have people that want to work. We have people that get work when they can and insurance is not provided.

Northern Michigan Hospitals, where I work, has been charged by the State Department of Public Health to serve the high risk prenatal needs of the northern end of our State; and also the eastern portion of the upper peninsula, including three islands—Mackinac, Drummond, and Beaver. Those are the kind of geographic access issues to which I am referring.

Besides those obvious barriers the providers are maldistributed. We have many counties that do not have a physician, let alone a physician who would be willing to render prenatal care, has the capability of rendering prenatal care, or even has a hospital in which they can deliver patients.

District 3 will be approaching us this week because yet another county has physicians who have indicated that they are no longer willing to take Medicaid. Philosophically, my hospital, Northern Michigan Hospitals, has accepted the burden of providing care for those patients. The number of uninsured is rising every year and the Medicaid rate is about 33 percent. This is particularly crucial in my world because we suffer from what I call "small numbers disease." We only deliver about 900 births per year. So that disproportion affects us more noticeably than if you had larger volumes.

We have developed an innovative approach to shared care in order to help our colleagues who send us high risk patients. That program is known as "Shared Care." It is a program where the women seeks prenatal care, perhaps, in Rogers City over on Lake Huron. Most of the time she seeks prenatal care on Lake Huron and in Petoskey some of the time; but all along the intention is that she is to come to Petoskey in order to deliver.

Now for those of you who have had the distinct pleasure of visiting Northern Michigan, it is lovely in the summer. We are happy that we have I-75, but transportation and the ability to get around is certainly impeded in the winter time.

This particular program has also been hindered in that in the recent past two hospitals have closed their delivery services and unlike other cities in which I have worked—large cities where it would be problematic if the hospital across the street closed down, these are hospitals that are 45 minutes away, on Lake Huron or across the bridge in St. Ignace. So it is not as though patients have another option.

Many times, by virtue of our geographic location we end up rendering high risk care that we truly understand we really had no business trying to render. We are a stabilization hospital for ultra

high risk. Sometimes, however, clients cannot get to down-State perinatal centers, won't go, or cannot afford to go.

Senator RIEGLE. Or they get there so late that the problem is so extreme.

Ms. LINCOLN. Well particularly in the business of pre-term labor, which happens in 10 percent of all deliveries in this country, causing 75 percent of the mortality and morbidity. We do not have time. Any way you cut it, it is 5 hours to Ann Arbor and they may have to fly. It makes it very problematic.

Access issues are not limited to all of the above. They also happen to be involved in the support services like mental health. The mental health provision that we are able to provide right now has been identified that they are missing 40 percent of the clients that need mental health; and that they are only able to provide marginal crisis intervention. Transportation, again, is a clear barrier.

Regarding comments made about a given county public health department, many of our county public healths incorporate four or five counties and that is one public health department. Provision of dental care to the underserved and unserved is also a clear problem because there are many dentists that are not participating.

The following programs that we have known to be successful on a State level or either extinct or endangered. And I cannot tell you today because every week something else went on the block and another program was added. But they include and are not limited to: Outreach for Maternal Child Health; the availability of health care providers; production of vaccines; general fund support for WIC; family planning services which obviously impact my clinical areas; and professional and para-professional outreach, as well as training for physicians to be able to practice in rural America and/or certified nurse midwives is constantly in danger.

Increasing eligibility for the uninsured and underinsured is a moral commitment that we all need to embrace. In my reality, however, it would inordinately burden the already overburdened system to the point that I do not know that we could provide the services. So this is a clear issue that has to be tackled.

Senator RIEGLE. We are going to have to do more with respect to building an infrastructure. If we are not going to have a form of Appalachia in northern Michigan or in our rural areas where this endemic poverty is sentencing people to short lives and miserable health problems, we are going to have to face up to some structure changes quite apart from universal access. We need both.

You make that point very well and I hear you making it.

Ms. LINCOLN. Thank you.

[The prepared statement of Ms. Lincoln appears in the appendix.]

Senator RIEGLE. Thank you very much.

Let me say I think we deserve—we ought to give a round of applause to both Sue and to Valerie for having come such great distances to be with us today and to present this important testimony. [Applause.]

I want to say that we are working, and I am really leading this effort, to increase the maternal and child health block grant by \$125 million, which is not enough, but will make a difference if we can get that accomplished. And it is very tough in the face of the

whole budget summit that is going on in Washington these days. But we are doing our best to get that accomplished.

Let me thank you both. I want to also make it easy for you to excuse yourselves too if you need to leave because I know you have the flu and you have the 4-hour drive ahead of you. We especially appreciate your making the effort.

Let me know go to our final witnesses that we have scheduled for today. Mr. Tom Rozek is the president and chief executive officer of Children's Hospital of Michigan in Detroit. Mr. Rozek will discuss his institution's activities and concerns on the issue of providing medical care to uninsured and underinsured children.

He is accompanied by Dr. Sheldon Brenner, who is the director of ambulatory pediatrics.

I want to thank you both for being here and for your patience through our hearing today up to this point and to say how important it is that we get the perspective now of a major urban center that you bring side by side with what we are hearing about some of the observations and difficulties in the most rural areas of our State.

They will be followed by Dr. Marvin McKinney, who is the director of planning and community affairs for the Mott Children's Health Center. He is also board member and representative of the Michigan Maternal and Child Health Council in Flint. Dr. McKinney will provide testimony on the special problems for minority families needing health care services for their children.

Gentlemen, we welcome you and we are very appreciative of your being here and your testimony. Mr. Rozek, we would like to hear from you now.

STATEMENT OF TOM ROZEK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CHILDREN'S HOSPITAL OF MICHIGAN, DETROIT, MI

Mr. ROZEK. Thank you, Senator Riegler.

Ladies and gentlemen, my name is Tom Rozek. I am the president of Children's Hospital of Michigan, located in Detroit. With me is Dr. Sheldon Brenner our director of ambulatory care services at the hospital. We appreciate the opportunity to appear before you today to address issues and concerns regarding the medical care of uninsured and underinsured children. We have already submitted written testimony so we will be brief.

Senator RIEGLE. We will make your full written statement a part of the record; and we are very appreciative of having it.

[The prepared statement of Mr. Rozek appears in the appendix.]

Mr. ROZEK. Thank you.

Children's Hospital is a 290-bed nonprofit pediatric hospital treating diseases and disorders of children from birth to age eighteen. In 1989 Children's had approximately 12,000 in-patient admissions, more than 150,000 out-patient visits, including over 60,000 emergency room visits, all provided without regard to a patient's ability to pay or insurance coverage.

We are the primary pediatric teaching facility for the Wayne State University School of Medicine and the major pediatric refer-

ral center for southeastern Michigan and the entire State of Michigan.

Generally speaking, there are four issues that have a direct bearing on access to health care—insurance eligibility, insurance enrollment, covered services and provider reimbursement. All four come together to determine the accessibility to health care for our children and their parents.

Senate bill 2459 introduced by yourself, Senator Riegle, along with Senators Bentsen and Chafee, will do a great deal to improve access by placing additional requirements on the States regarding all four of the previously mentioned issues. Unfortunately for Children's Hospital of Michigan and its medical staff, however, the State of Michigan's major problem with the Medicaid program is that it simply does not have enough budgeted money to pay providers adequate sums to assure access to these services.

For instance, the Children's Hospital provided care to nearly 64,000 Medicaid patients in 1989 and suffered a loss from operation for providing these services to the tune of \$5.7 million. This is in addition to the loss of \$5.6 million we wrote off as uncompensated care or bad debt and the additional \$1 million we lost from the provision of Medicare services for patients primarily cared for for renal dialysis services.

In order to make up for these losses we have to charge all payers higher rates in order to make a very slight income from operations in 1989.

Regarding our physicians, pediatricians—

Senator RIEGLE. If I can interrupt you at that point, because we have such an important audience of citizens present, what he has just said is important to not just pass by unnoticed. That is that because of all of the uncompensated care that they have had to deal with in the last year, roughly \$13 million worth or thereabouts, the only way they can continue to operate and keep the doors open is to load that cost on the paying customers.

So the cost of the services to the paying customers is driven up by that amount and, of course, then those insurance companies and providers of health insurance—maybe it's a private company or what have you—see their rates rising sharply to cover those individuals. So they start cutting back on their health care coverage for those families. And this gets into some of the renegotiations we are seeing in labor contracts and such, and where businesses, even without labor contracts, are finding that they are having a tough time coping with their rising health insurance premiums and so they are cutting back on their coverage. They are either shaving off family members or requiring more co-payments by their workers.

So the problem feeds right back into the health insurance system and ends up affecting everybody pretty much that has health insurance. So whether you have your health insurance through your work place or even if you have it privately, you are seeing the rates being driven up higher and higher in part because of this uncompensated care that is having to get loaded into the rate structure.

Just to take it one step further, I had a very powerful illustration in terms of how it affects jobs and our competitiveness of a

company. The Chrysler Motor Car Co. came in to see us the other day and pointed out that the cost of health insurance for their work force and for their retirees on a per car basis was running about \$580 a car. That is just the health insurance bill that gets assigned to each car that rolls off the production line. So that has to get built into the cost of selling the car and trying to recoup that money.

They pointed out that if they build the same Chrysler car across the Detroit River in Windsor, Canada where the Canadian health care system is, of course, different than ours, the health care costs to cover a Canadian Chrysler worker is only about \$200 a car. So there is a big disadvantage to building that car in say Michigan with the higher health costs attached to it than building that same car just a few miles away in Canada where it had a lower health care cost associated with it.

Now that becomes a very complicated discussion when you start comparing the Canadian health care system and the U.S. health care system, but the more you are reading about the loss of good jobs in this country to overseas competitors—whether they are in Canada or Japan—part of it is the cost of production that represents these inflated health insurance costs because the system is so lop-sided. We do not have a universal system for people who are coming in now and getting uncompensated care. If they were somehow being covered in a sensible arrangement, which we think we can devise, that would reduce some of this cost pressure on the current insurance system and would help us retain our job base and our economic competitive position in the world.

I only take a moment to interject that, because all of these things interconnect. If we are going to have a good solid country for the future, with healthy people, with good jobs, and with a decent income to do the other things we need to do, these things have to be kept in some sensible balance. And the health care problem right now, getting it reorganized and getting everybody covered in a sensible way, is one of the most important economic initiatives that we can take for America.

So, on the one hand there is a moral imperative and a human imperative in helping our people—especially the children who are the focus of our hearing today. But on the other hand, we need to do it in order to get our economic system on a solid footing so we can compete in this new global economy. So, however you look at the problem, it is absolutely essential that we face up to it and correct it; and work our way through to some rational solutions and changes that can let us get the benefits that we are trying to illustrate here today.

But thank you for letting me just interject that note. Why don't you continue.

Mr. ROZEK. Regarding our physicians, pediatricians make their living from office practices. The payment for a normal office visit made by three employer-based programs in Detroit averages \$48 per visit. This was for a population for which the physician knows, has the records and does not take much time.

For Medicaid program enrollees and the uninsured, the episodic nature of their health care requires more time per patient because of a lack of continuity and the complexity of the social and medical

problems many Medicaid patients have. And for this service the average Medicaid payment is \$16 per visit.

Is it any wonder that many doctors will not take these new Medicaid patients and that consequently many of these patients end up in our general medical clinic or in our emergency room?

Finally, many third-party reimbursement systems discriminate against the pediatrician. To describe this, I would like Dr. Brenner to relate to you a story of an encounter he had with an official from the State Medicaid program.

Senator RIEGLE. Just turn the mike right around. Dr. Brenner, we would very much like to hear from you now.

STATEMENT OF SHELDON BRENNER, DIRECTOR OF AMBULATORY PEDIATRICS, CHILDREN'S HOSPITAL OF MICHIGAN, DETROIT, MI

Dr. BRENNER. Thank you. I will be very brief in my statement. I would like to applaud your support of legislation that is geared to universal access of health care for all children.

In your opening statement, Senator, you mentioned that many physicians will not participate in the Medicaid program because of low reimbursement and the bureaucracy and paperwork. I think that is a part of the current problem, and a major part of the current problem is as Mr. Rozek stated.

But the incident I am going to talk to you about has more to do with the philosophy of reimbursement. The philosophy is such that it is not as important what you do for the patient as what you do to the patient that determines the reimbursement.

Let me give you just a little background. I direct ambulatory services at Children's Hospital; I am also a part of the faculty that is responsible for the education of third year medical students and the pediatric residents. Everyday I am exposed to medical students discussing career opportunities and what they are going to do. My fears are of what is going to happen in the future to primary care physicians because a major portion of access is not only financing or making sure that everybody has the ability to pay for their health care, it is also that someone is going to be there to provide the health care. I am worried and concerned about the number of medical students who are choosing to go into the surgical subspecialties that reimburse very highly.

The story I want to tell you is an encounter that I had with a professional service representative from Medicaid. We were going over our patients' encounters trying to figure out how and why we get reimbursed for certain procedures or seeing certain patients. We discussed a patient who came into our clinic and was seen by one of our attending physicians and a resident.

The child was a 10-year-old girl who came in with a complaint of abdominal pain. The resident proceeded to talk to her, take a history, find out that she was from a single-parent family, mother was involved with drugs at the time and often left this child alone. The child was frightened; she lived in a high crime district. There were a lot of fears.

The description of her abdominal pain certainly did not meet the criteria for any disease process. The resident examined the child

and determined that this was unlikely to be a physical problem and spent 45 minutes or an hour going over the lack of positive physical findings and why she might have this pain, et cetera, and what one can do about it.

So we discussed that with the representative from Medicaid. I said, you know, we only got \$16 for that visit. And he said, well, you didn't do anything for her. That was his answer, "You didn't do anything for her." I said, "We found out the reason for her illness. We discussed it and we reached a conclusion without utilizing laboratory procedures, x-ray and expending so many dollars that could be used to provide care for people who truly need it." And he said, "Well, you didn't do anything for her." He suggested we should have a gastroscopic exam, an upper GI, a blood test, urine, et cetera, which was totally unnecessary. But the philosophy is based upon motive.

Senator RIEGLE. What would it cost to do all those tests?

Dr. BRENNER. Oh, I would imagine a minimum of \$500. A minimum of \$500. And we are taking away care—those dollars could have been spent for—

Senator RIEGLE. For an inhaler.

Dr. BRENNER [continuing]. An inhaler, et cetera. Precisely the point.

So my concerns are that the reimbursement philosophy certainly impairs the quality of care. Because that was fine quality of care without drawing blood or invading the patient in any way whatsoever. Secondly, it does increase the cost tremendously, unnecessarily so, but one is driven to doing that because that is how they are going to get reimbursed. But more important, I think that this method of compensation, by having to do something, by not having to listen to the patient and talk to the patient, but doing a procedure.

Senator RIEGLE. Yes, some kind of applied medicine.

Dr. BRENNER. It is driving people out of the primary care field and into specialties for which procedures will be reimbursed.

Just in closing, it has always struck me very funny that I could spend an hour with a family with a child who has a school problem or a learning problem and get reimbursed whatever the prevalent rate—whether it be Medicaid or whatever the family will pay. And a child may come in with an abrasion or laceration and I can wash it and put a dressing on it and get \$65 or \$75 for that because that is a procedure. It does not require any skills or knowledge, but it is a procedure, versus the \$16 you get for really intermingling and helping someone.

Senator RIEGLE. Thank you very much for those illustrations.

Mr. ROZEK. We want to thank you for your help, Senator Riegle, and pledge our support for Senate bill 2459. We also wish to encourage you in your activities on the Bi-Partisan Senate Working Group on Universal Access since many children will never be eligible for Medicaid.

We would like to close with a quote from a great philanthropist and a former resident of your home town, Flint. Charles Stewart Mott once said, "If anyone is going to do anything on earth to help humanity, doing something for children is a great place to start."

Thank you for your time.

Senator RIEGLE. Thank you very much. [Applause.]

Let me indicate our sign language interpreters have to leave now and I want to just thank them for their work. Let's give them a round of applause. [Applause.]

I think this last discussion also provides a very natural way to go to the Motts Community Children's Health Center witness who is here with us. Just before doing so, let me indicate that I think what we have just heard are some very important illustrations as to how the system of health care needs to be reengineered—the system and the reimbursement system.

These things are complicated, but they are not so complicated that we cannot find answers to them. You know, rocket science is very complicated. It was very difficult to figure out several years ago how to take men to the moon and land them and bring them back safely. We spent an awful lot of money doing it. It was very complicated. Far more complicated than figuring out frankly how to fix our health care system.

The problem is that we have not put the emphasis and the attention on it sufficiently. One of the reasons that we don't, as a rule, is that the problem is big enough and comprehensive enough, that if you just take part of it, it is very hard to make sense of it. What we have tried to do with this hearing today is to construct a hearing that covers essentially the main dimensions. So you can start to see yourselves, those of you that are here listening today, in a sense sort of the overall outline and shape of this problem.

And our expert witnesses, because they are willing to prepare and bring such good testimony can help fill in the pieces, so that we start to see the cross connections and the engineering design of what the current system looks like and how we might start to take it apart and adjust it and modify it and put it back together again so that it will work even better, but on a much broader base so that we do not end up missing, particularly all of these uninsured people and all of these children—the 300,000 of them in the State of Michigan alone—who are right now on the outside looking in.

Those of us in this room who God had favored in such a way that we have health protection ourselves or for our families, we can go home tonight with that degree of comfort in our lives, must not forget for a split second about these other families that are going home tonight and are around our State in very substantial numbers who have no health protection for their children and who are frightened always that when that pain crops up, whether it is an abdominal pain or some other kind of a pain that appears or sickness that appears. That little tyke needs help, boy, if America is not willing to help make sure that that family is in a position to respond, I think we are way off the track as to where we should be as a country.

Hopefully, with this hearing and the work that we are doing, together with the very competent staff people that are here with me—and I want to recognize them both because they have done such an outstanding job. I have some out in the audience here too. I do not want to miss anybody's name. So I will do that in a minute.

But before coming back to that and with some concluding comments, Dr. Marvin McKinney, who I introduced earlier, is the di-

rector of planning and community affairs for the Mott Children's Health Center in Flint. With that very appropriate comment from Charles Stewart Mott, Sr. that preceded your introduction, that is probably a good way for us to bring you on.

Thank you very much for being here and we would like to hear from you now.

STATEMENT OF MARVIN MCKINNEY, PH.D., DIRECTOR OF PLANNING AND COMMUNITY AFFAIRS, MOTT CHILDREN'S HEALTH CENTER; BOARD MEMBER AND REPRESENTATIVE OF MICHIGAN MATERNAL AND CHILD HEALTH COUNCIL, FLINT, MI

Dr. MCKINNEY. Thank you. Senator Riegle, I wish to thank you for this opportunity to serve as an expert witness on the health conditions and problems of African American children, with particular reference to that segment of this population within 150 percent of poverty.

I especially want to thank you for having the vision and the insight to not only seek an understanding of the plight and crisis experience by a large segment of our urban population, but to go even further as witnessed by Dr. Brenner, in your quest by examining the peculiar institutional behaviors that often times results in a lack of sensitivity to a most proud and most vulnerable group of human beings.

It is especially important that it be noted for the record that I, as a witness, am all too aware that although I pride myself on my scientific training that I am a black man socialized in America and thus historically I submit that I have been a participant observer that often times overrides my academic preparation.

My comments will be directly related to the African American community in Flint, MI. However, I submit that any community of color with the indicators of a high rate of unemployment, a high rate of incarceration, a financially strapped public school system, and a high rate of infant mortality, will also reflect similar trends.

Gunnar Myrdal wrote "The American Dilemma" and James Baldwin wrote "Another Country." Both talk about the discrepancies between black and white America. The contrast between African and white Americans is even more evident when one reviews the health statistics of the present time. I would like to reflect on some of these data before I get into my testimony, particularly as it relates to Flint, MI and a study prepared by Dr. Kurt Gorwitz and myself.

One out of 15 Michigan residents are black; 1.3 million black residents lives in the State of Michigan. Genesee County has 440,000 residents, 20 percent of which are black. Only Wayne County has a greater number of lower proportion black residents. As much as the rest of the State, Genesee County's black population is in an ongoing transition with a widening separation into two primary groups based on socioeconomic status—that is, the haves and the have nots.

One out of six of 14,000 black residents in Flint, MI have no health insurance and 26.5 percent are on Medicaid.

One out of seven black babies weighs less than 2,500 grams at birth, compared with one 1 of 20 white babies. On average, black babies weight 200 grams less than their white counterparts.

A black baby now is three times as likely to die in infancy as a white baby. The black infant mortality or death rate rose from 19.2 per 1,000 in 1980 to 25.3 in 1987.

One out of five black infant deaths is due to reduced length of pregnancy and low birth weight, while 11.4 percent of white infant deaths results from this factor. The primary cause of black infant mortality is respiratory distress, commonly is related to premature delivery.

These statistics only tell the quantitative outcome or part of the story. They do not speak to the antecedent underpinnings of people who live in poverty and their relationship to a foreign system of health care. We do not expect these statistics to be changed any time soon. Some of the antecedents to the problems are so deep seeded that an evaluation design that does not target across generational change may be unwise. The problems are not intractable but they are multi-causal and multi-faceted, and must be attacked through those institutions that have authenticity and credibility within the black community.

Each year at Mott Children's Health Center in Flint, we provide service to approximately 20,000 children who are within 150 percent of poverty. Of those 20,000, 5,000 are medical patients and 5,000 are dental patients. About 5,000 of our patients have no insurance; and about 60,000 or 11,000 are on Medicaid. The addition 15 percent of our patients have some type of insurance, but we absorb the deductible which in some instances are as high as \$500. We do not charge any patient fees.

Last year our medical department returned 25 percent on each dollar that we spent. We also see about 5,000 clients in our psychology department who need psychological support for which there is even less reimbursement. So the level of reimbursement is a major problem for providers of care to low-income people.

In Kalamazoo, MI of which I am sure you are aware, a hospital had to turn away 3,500 Medicaid recipients because it could not keep its cost. Two perfect examples of this at the Mott Children's Health Center is that to do a pediatric physical examination costs us about \$25 to \$30. We get reimbursed \$11. In the dental department, to do a screening which includes a prophylaxis and two x-rays costs us about \$55 to \$60, Medicaid reimburses us about \$22.

The Michigan Council for Maternal and Child Health has gone on record in supporting expanded services and access to care. Unfortunately, without the necessary resources, this becomes a false promise.

So you can see that Medicaid can be construed as a false promise because for some clients and some providers it is a promise that cannot be kept. The council has also expressed that the health care delivery system for specific and culturally diverse populations must be designed to expand access and support provided in promoting nontraditional prevention and treatment programs that are respectful and understanding of the recipients environment. But even if the program was fully funded, barriers to care would still exist. I hope the following examples will illustrate my point.

Most black low-income people in our city are isolated and invisible to the power people who make decisions about how they shall live and what services they will receive. But the most sensitive of this power group has no direct contact with the most vulnerable among us. It is business as usual or policy from a distance.

At the Mott Children's Health Center it is not unusual for an appointment to be broken. As a matter of fact, we have a consistent 30 percent no show rate over time. And even though we attempt to remedy this by over booking, this clearly is not the only answer. In 1987 we conducted a no show study that has helped us to modify some of our services.

The most noted responses as to why people didn't show up was lack of reliable, dependable transportation; inconvenient clinic hours, especially for the working poor; lack of safe access to a telephone to cancel an appointment or even to make an appointment; and a family emergency that took precedence over the appointment; or a perceived lack of sensitivity regarding adolescence, race and poverty.

In one case a mother shared with us that she wanted to keep her appointment but it was so cold and snowing outside, and she had no one to watch her sick child, and she was afraid to walk to the telephone booth. In another example, a mother and her children were getting ready to board a bus and they were accosted by a person carrying a gun demanding money.

Most clinics in our area, save emergency rooms, have operating hours of 8:00 to 5:00. For a working poor family, it means that they have to forego a day's pay to make a clinic visit. This is a most precarious decision to make.

In Flint, like many other cities, the health care treatment system is predicated on people who have ordered and predictable lives. It is predicated further on people who are future oriented and seem to feel that they have some control over their lives. This is not always the case for low-income households especially when the household is headed by a single, adolescent mother who resides in a community where turbulence and violence can emerge at any time.

Any health care access project must understand that there are certain barriers to health care irrespective of the size of the funding source and allowances must be built into the legislative policy. My overall assessment of the continuity of health care policy for low-income people is that it should be redesigned to reflect the needs of the people for whom it is intended.

To the subcommittee I offer these following recommendations: The reimbursement rate for medical services rendered should be reflective of the actual cost. Financial incentives should be available to providers for offering services with extended and weekend hours. Provider clinics should be expected to have a minimum of 50 percent of its clients to be walk-ins. Transportation costs should be covered for families, especially those in need of emergency care. Provision and reimbursement for mental health services without a psychiatric oversight should be a part of the reimbursement service package. Financial incentives should be available for the treatment of multi-problem families, inclusive of parent education and health education. Currently, there simply is no time to do that.

Health services should be placed in the communities with other human service agencies to promote a one-stop shopping and promoting a community safety zone such as public schools with declining enrollment. Most importantly, community leadership must somehow be built into the reimbursement mechanism to assist in ongoing community involvement and empowerment.

Plain and simple, if we do not begin thinking and understand the multiple, deleterious and injurious aspects of the inner city we will most assuredly lose at a minimum, two generations of human beings. We lose them to drugs, premature parenthood, violence, imprisonment, infant mortality, unacceptable social and emotional behavior, and most dastardly with recalcitrant and punitive social and public policies that will be designed to control and contain rather than to support and ameliorate the problems.

I would like to close by saying that relative to health no variable is more predictive than income and appropriate insurance coverage. The connection between race, poverty and rotten health outcomes cannot be denied. The extent to which such outcomes are predictable and not random is the extent to which we must alter our traditional perceptions of health care delivery.

Once again, I would like to thank you for this opportunity in presenting these views. I would also like to thank Valerie Lincoln. Because I think that what she has pointed out is that there are so many similarities between the rural poor and the urban poor.

Thank you.

[The prepared statement of Dr. McKinney appears in the appendix.]

Senator RIEGLE. Thank you very much. [Applause.]

I want to make, if I may, a couple of observations. I now it is late in the afternoon and people have been sitting patiently a long time.

I was so struck by some of your observations in the early part of your comments. I was reminded of a visit I made recently to the Afro-American Art Museum in Detroit. Anybody here who has not had the occasion to do that, I would like to urge you to build it into your plans sometime when you are down there. I'm going to describe one of the most striking aspects, and I think it relates to where we are today and how perverse patterns continue on through generations and through time.

There is a very powerful display there of a slave ship of the kind that was used when African Americans were being captured in large numbers back hundreds of years ago and put in chains and brought over on slave ships. They actually have a design of a slave ship laid out, with the design of where the people were stacked on the floor, laid out on the floor like logs. And so in every square inch of the hold of the ship the slaves were made to lay in an assigned spot, side by side, all the way right up into the front corner of the ship, which is of course on an angle. So some person was actually forced to lay there in a curve position so that they could wedge one more person in that slave ship.

They describe how in the course of the terrible travail of being taken into human bondage and being taken on these slave ships across the ocean, of course, many people died on the way. But as they would come across the ocean and start up from South and

Central America and up through the Caribbean and up the coast of the United States the exhibit described out how they would take very often the children and the women off at the early stops. I mean they would just—the families would just—if they were intact when they got on the ship were not intact when they got off the ship, because they would drop people off at different destinations and they would keep only the strongest and physically durable people on the ship to take them all the way up the east coast of the United States before they would be off-loaded and sold in slave markets.

I do not know that anybody, even reading that period, and studying that period, and looking at these diagrams, and things that we have from that time, can begin to comprehend the enormity of the crime that was being perpetrated in that era of human history. I mean we study other parts of our history—the Holocaust and other things we pay appropriate attention to. I do not think we have really taken the time to understand how in years past, with respect to African Americans particularly, people who had among the strongest and the most stable family cultures anywhere on the globe, and who worked and lived in family units, were literally torn to pieces for economic reasons and scattered to the four winds.

And in the passage of time, from the days of the slave ship until today, is like 10 seconds of time as we reckon time across the great ages of time. The perversity does not begin to be an adequate word. But the horrific realities of that period of history and what it visits upon us even to this very day, right down to and including racial attitudes that many people in the non-white community have and must struggle against to change are born out of a history that most of us do not understand very well because it is not our history and we have not paid attention to it. We do not study it much in school. In fact, I do not recall ever seeing in the schools that I went to a single page devoted to the kinds of illustrations that I have seen in visiting places like the museum that I described in Detroit.

I take only a minute to say this because I think your powerful and illuminating comments about the health profiles that we are seeing today—I mean we are seeing this era's manifestation of a whole cascade of events and tragedies compounding tragedies that leave us with a situation today where the health profile and the difficulty profile with the health problems in our Afro-American community in the inner cities is a staggering, breath taking situation that is almost beyond our comprehension in terms of the scale in which it is occurring. If we do not deal with these multiple sensitive problems in an intelligent way and work them through with jobs and lots of other things, we are going to find ourselves with a situation that becomes less manageable.

It sounds to me as if your data is showing that, where we start to see a society that cleaves itself apart and maybe starts to lose the ability even to understand across the divide what is going on and who we are and how we are really all part of the same national family, I believe time is really running against us on this.

So I appreciate particularly you bringing that insight to this hearing and putting that kind of information on the record and in this hearing record. It helps illustrate as well the complexity of our problem. I mean even all the people of good motive that want to

approach this issue and try to figure out what we do about it, going from there to crafting a set of actions and solutions that is sufficient to do the job, it is just a huge and complicated task.

I want to finish the hearing today on that note, by saying to all of you that are in attendance and that have come and have spent this time, this is democracy at work. This is as close as you are ever going to get to being part of democracy in action in terms of how our government is designed to work through the holding of public hearings by elected legislators and representatives to try to collect the information that we need to understand and make some sense out of it and go back and start to reshape the public policies and the directions in government.

In this case, it is the Federal Government which has a particular role to play that you have heard from important State Government witnesses today as well. And so what we draw from this—all of us—is important. I have a certain role, however, as the chairman of this subcommittee to try to integrate this knowledge in my head with the help of terrific people like I have here with me.

Karen Gaffke, who is here on my right; and Debbie Chang, on left, who have worked countless hours together with other staff members who are here. Elisa Lancaster, and Chris Cresell-Korest, and Debbie Mason, and many others that have been involved to enable us to structure a hearing like this so we can try to collect the information that lets us move ahead, lets us figure out where we go next.

My point in saying all of that is that what you think, everybody that is sitting in this room right now, each and every one of you—and I am not speaking to our witnesses; I am not speaking to the person next to you—I am speaking to each one of you, what you think and how strongly you feel about the need to force change and action in this area is every bit as important as what I may think or what I may try to do as the chairman of the committee of jurisdiction in the U.S. Senate.

We need an engaged, an aroused public. We need people who are willing to talk about this at every opportunity and in every setting—in your work place, in your social activities, in your civic activities, in every manner and fashion in which we can get the word out. The idea that we cannot change things in this country is wrong. We can change things in this country and we do not have to accept things the way they are today. We do not have to let people get ground up in the wheels of the system that is not designed properly and that is not working properly.

We do not have to accept a situation where little girls as we heard earlier need inhalers and do not have them. It is a crime that that situation should go on for a single child in America. The fact that we may not know them does not really have anything to do with it. We should not have to know somebody to care about them. We should be able and willing to care about the whole of the American family without having to know each other. It is a privilege, in addition, if we get the chance to meet them, but that should not be the precondition for deciding to act.

So I need some help from you as well beyond today. I need everybody in this room to do the missionary work that has to be done to

get a higher, and higher level of visibility and commitment to moving to solve these problems.

Now I am absolutely determined that this committee that I have in the Senate is going to get health legislation that covers all Americans written and enacted. And with every breath and fiber in my body, I intend to see that it gets done; and I want to get it done at the earliest moment that we can.

I am going to need some help because there are still some "doubting Thomases" around who have great health insurance and do not think there is a problem because it is not their problem. And the fact that it is somebody's problem across town does not always cut a lot of ice with some people. It does cut ice with you because you are here and you are here because you care about these things and you are committed to try and make a constructive difference.

So I would conclude by asking our audience here to help us get this job done. You come from around the State. There are 18 members of the Congress who representing Michigan. They are in both parties. They all need to hear from you on the health care issue. They are all going to have to vote on it. We need their votes. We need a bi-partisan kind of commitment to get this done.

We need the President to become persuaded. We need to have him make health care the lead issue for 1991. We are part way through 1990 and they have sort of set their agenda for this year and the Summit is going on and a lot of other things. But we are getting all of the ground work done with hearings like this and so forth and designing these legislative alternatives and packages. But we are going to need to have a commitment at the top of our government by the President, by the administration, together with the Congress to move on the health care issue and to move on the access issue.

If they get the clear sense that that is what the public wants, that is where they are going to go. That is where, I think, your part comes in—that is, we have to get the message across loud and clear from the grassroots, starting with the kinds of witnesses and providers and professionals that we have had here today, but also coming up through you, through your efforts and through your advocacy to make darn sure that we do not let more years slip by, more lives slip by, more decades slip by before we do what we should be doing this very minute.

And that is, providing basic health insurance coverage and decent health care for every last person in this country—man, woman and child, starting with the kids. Prenatally, and right through the day they are born, and right on out through the end of the line. That ought to be our commitment as a country. I think if we work together we can get it done.

Let me thank all of you for coming today. You have been terrific to come and participate. If anybody wants to give us a statement for the record we would be delighted to have it and we will include it in the record. I want to thank you all. I want to thank our witnesses again. The committee stands in recess. [Applause.]

[Whereupon, the hearing recessed at 4:10 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SUE ASHBY

Muskegon General Hospital provides the community with three programs which have direct, positive effects on the health status of children and families. These are:

1. The Family Health Center—a Family Practice Physician Residency Training program which accepts patients of all ages independent of their insurance or ability to pay.

2. The OB High Risk Clinic—a program operated cooperatively with the county Health Department which has decreased the infant mortality rate from 10.7/1000 in 1987 to 7.0/1000 in 1988, the latest year for which figures are available.

3. Recovery Care—a subacute substance abuse program which provides detoxification and residential treatment to Medicaid eligible patients and coordinates services with the OB High Risk Clinic to deal with chemically dependent pregnant women.

In addition, Muskegon General Hospital is interested in and has engaged in discussions about:

Designing a Preferred Provider Organization, as a demonstration program, for families of the working uninsured. This would be possible because of the Family Health Center.

STATEMENT OF THE PROBLEM

1. Medicaid—Many individuals are covered for health care benefits through this Federal/State program but still are unable to receive the medical services which they need. In Muskegon, most physicians are not accepting new Medicaid patients. Almost all physicians see some Medicaid patients; however, Family and General Practitioners limit their Medicaid patients to a percentage of their total patient mix. The reason physicians, hospitals and other health service providers prefer to limit the percentage of their Medicaid patients is inadequate reimbursement.

2. Access to Services—Families covered under Medicaid have difficulty accessing health services. Without preventive and primary care, many children and families suffer more serious health problems and complications than would have been necessary had they been able to access services early.

3. Cost to the Community—The community bears the burden of inadequately insured people and their lack of access to services. It is a fact that it costs far less to prevent a serious health problem than to treat it. Health services providers have fixed costs which must be met. when reimbursement is insufficient from one payer, the costs are shifted to other payers which results in increased costs throughout the community without actually addressing the problem.

4. Working Uninsured—Many people do not accept job training, paid education, or employment because they would lose their Medicaid benefits. Even though there may be a good possibility of health care coverage from their employer in the future, they will not forfeit their current health care coverage. The effect on the economy, as well as the effect on the non-productive welfare cycle, is event.

5. Additional Need—The Emergency Room sees approximately 4000 patients annually (25% total volume) for problems that should be taken care of through routine infant, child or primary care services. Inadequate access to and lack of acceptance into primary physician practices results in increased costs to the community and decreased health status of children and women.

MUSKEGON GENERAL HOSPITAL'S APPROACH TO THE PROBLEMS

The Family Health Center meets two needs: (1) it provides a supervised, clinical training site for physicians in the hospital's Family Practice Physician Residency Training program; and, (2) it provides medical care for many individuals who would otherwise only receive care through emergency departments of hospitals.

Initiated in August, 1989, the Family Health Center serves over 500 patients, with only one Resident at present. Individuals who are covered by Medicaid, Medicare, and/or private insurers receive services through the program. Patients are not denied services due to inability to pay. The full range of family practice health services are offered, from prenatal to pediatrics to geriatrics.

The center is designed to be economically self-sufficient on the current payer mix of patients. However, a decreasing three-year grant from Health and Human Services was awarded the program to cover any shortfall on operational costs during this start up phase.

The OB High Risk Clinic also operates in conjunction with the hospital's Obstetrics and Gynecological Surgery Resident Training Program. The physician support, which is possible only through a Resident Training program, has been the cornerstone for the success of the High Risk Clinic.

The Muskegon County Health Department provides prenatal education and testing for the Clinic participants. Over 400 women participate in the clinic on an annual basis, all of whom are on public assistance, and many of whom are uneducated in the importance of prenatal care the health of their future children. The infant mortality rate in Muskegon County has decreased dramatically since the hospital has been working with the Health Department through this clinic.

The positive effect of those High Risk Clinic extends beyond just the infant mortality rate. Poor, uneducated girls and women receive training in infant and child care. Further, they are introduced to many community resources which have the potential to reduce or eliminate future health problems for their children.

The Recovery Care program has served 132 patients in its first 9 months of providing substance abuse services. Of these 132 patients, 90% were on Medicaid. Prior to the hospital initiating this service, there were no other local programs which would accept Medicaid patients—an obvious contradiction since a disproportionate share of the chemical dependency problem is among the Medicaid population.

Chemically dependent pregnant women are served in Recovery Care. With increased awareness of the problems of pregnancy and chemical addiction, the legal ramifications (especially in Muskegon County), and the hazardous effect on the children of these women, the hospital has dedicated many resources to working on treatment options. It is unique that the Muskegon General Hospital offers both a substance abuse treatment program and a high risk OB clinic. The professional and medical staff of the programs are able to work cooperatively to identify ways to address the specific problems of this target population.

Muskegon General Hospital is very concerned about the growing problem of chemically dependent pregnant women and how their substance abuse has a lifetime effect on the health of their babies. The hospital is in a unique position to have an impact on this growing problem of overwhelming significance to individuals, the health of children, and the costs to communities. While we have and will continue to treat chemically dependent pregnant women, additional funds are needed to expand the services. Special training for physicians and other gatekeepers, outreach to the target population in the community, and a specially designed counseling program are needed.

It is a sad fact that in 1989, 42 women presented themselves at the emergency departments of area hospitals for the birth of their babies and stated they had no prenatal care. Many of these women were suspected of or had a history of drug use and many of their infants showed signs of fetal distress.

Muskegon General Hospital's commitment to provide care for the medically underserved is also seen in our physician recruiting and practice guarantee program. The hospital expects new physicians to accept Medicaid patients into their practice and this community benefit concept is explained to them.

DEMONSTRATION PPO FOR WORKING UNINSURED

Muskegon General Hospital is in an unusual position to provide health care services, through a Preferred Provider Organization, to the working uninsured. The mechanism for routine preventive and primary health care services is already in place through the Family Health Center. And, the vast majority of hospital services could be obtained through Muskegon General Hospital on either an inpatient or outpatient basis.

Funding for this could be through Medicaid, since the majority of participants would have previously had Medicaid coverage. With adequate PPO reimbursement through Medicaid, the necessary services for children and families could be provided. An additional provision could be to have the worker make a moderate monthly contribution to the "premium" for the Medicaid coverage. The worker would have an incentive to keep his or her job, would provide health care services for family members, and would take a step toward ending family patterns of welfare support. With adequate health care coverage, the cost-shifting and costs to the community which the working uninsured create, would decrease.

Muskegon General Hospital would be interested in working with government officials to become a demonstration project to provide health care services to the working uninsured.

CONTINUED ADEQUATE REIMBURSEMENT

Muskegon General Hospital is committed to providing needed services to people in the community. The programs previously described have had a significant and major impact on the health of children, women, and men in Muskegon County. No responsible hospital can continue to provide services unless it is getting adequately reimbursed, however. It would be bad business and unethical to continually operate at a loss and pass that along to other parts of the community.

And yet, that is what health care providers have been forced to do because of the inadequacy of government sponsored programs. Providers lose, communities lose and the families who are supposed to benefit from the programs lose, too, because they cannot access care.

PREPARED STATEMENT OF DEBBIE DYKE

I'm here today to tell of the dilemma I found myself in a few months ago. My name is Debbie. I have two daughters, Melissa, age 14, and Mindy, age 10.

Like most other Americans, I always had every hope of getting a job and supporting my family. After my divorce some years ago, I became eligible for assistance from the Aid for Families with Dependent Children Program. But in 1988 the State started a program called Job Club. It was designed to help Department of Social Services (D.S.S.) clients find full-time work. I was in this program for 6 months when I landed my full-time job in May 1989. I worked 40 hours per week and made \$5.00 hour. I was really happy and felt good about my independence.

The only problem was I had no health benefits. I was told when I took the job that my employer was going to offer medical insurance. He never did. At the same time, my D.S.S. caseworker informed me that as of November 30, 1989, my children and I would no longer be eligible for Medicaid because my new income made me ineligible.

Finding yourself without health care coverage is upsetting for most families. But for my family the situation was more than upsetting—it was frightening. My oldest daughter, Melissa, has severe Bronchial Asthma. She is on three different medications daily to keep her asthma under control. She has two inhalers she uses four times daily. Her Proventil inhaler runs \$19.00 and her Intal inhaler runs \$25.00. Her inhalers last only two weeks. She also takes Proventil pills three times a day which run about \$20.00 a month. Melissa also takes Prednisone when she has a bad asthma spell.

After our Medicaid card expired last fall, we were really in trouble. I was making about \$180.00 per week. After paying rent, utilities, gas to get to my new job, food, and other essential living expenses, there was not much left over for these medical bills. Just where am I supposed to go to get the money to pay for these medical costs? And these are just the expenses that I know we will certainly have. What happens when Melissa or my other daughter get sick, falls and breaks a leg, or worse yet, needs an operation? Where do people like me and my daughters go for help?

We were constantly worrying about where the money for Melissa's next inhaler would come from. The school nurse would call me at work to tell me that Melissa couldn't breathe. I would have to talk with her over the phone or go to the school. Melissa and I would end up arguing about how often she could use her inhalers. How are you supposed to tell your daughter that she must use her medicine less because her mother doesn't make enough money to buy her what she needs. The school even ended up buying her an inhaler to keep with her during classes. My grandmother Mudge also helped out when she bought Melissa two inhalers for Christmas.

The nurse at school called Social Services to tell them of her condition and that she needed to have the inhalers to breathe when she had a spell. But they could not help since my \$5.00 an hour salary prohibited us from qualifying for the program.

My other daughter, Mindy, got a severe sore throat last winter when we were without insurance. I wanted to take her to the doctor for an antibiotic when it didn't clear up in a couple of days. I couldn't, however, because I didn't have the money to pay for the office visit.

From December 1989 to February 1990, I spent over \$150.00 on prescriptions alone. You see, I also have asthma and need prescriptions to keep my condition under control. When you're making less than \$200.00 per week, you don't have to do a lot of figuring to know that it's next to impossible to make ends meet.

I kept asking my employer to please get health coverage for the employees. The company recently made some changes and I was laid-off. I believe that if I hadn't continued nagging my employer for these additional benefits, they would have been willing to train me for additional job responsibilities.

As of right now, I do have Medicaid back for my children and myself since I'm drawing unemployment benefits. Because we have good access to health care through Medicaid, Melissa no longer gets all upset when her inhaler starts running low.

I honestly don't know what people in my situation are supposed to do. I want to work and support my family. I very much enjoyed working and earning my own way. But when having that job ends up penalizing my children by denying them needed and costly care, what am I supposed to do? My employer didn't offer benefits, I didn't make enough money to buy private coverage, and the state had to cut me and my children off Medicaid because I made too much money.

We have to do something about this problem of health care for our children. As for me, I'll do what I have to in order to keep my children healthy, happy, and safe. If that means staying on A.F.D.C. in order to keep Medicaid for my children, I'll do that. Until something changes or I can find a job with health benefits, I cannot justify putting my family through an ordeal like that again. After all, my daughters' health is much more important than my pride.

PREPARED STATEMENT OF VALERIE LINCOLN

Hello, I'm Val Lincoln and I'm here to share a quick vignette which represents the issue of the uninsured and underinsured from the eyes of rural Northern Michigan. I do so wearing many hats. I am currently the Service Line Director of Women and Children's Health at Northern Michigan Hospitals, Inc. in Petoskey. Prior to this, I was the Regional Perinatal Coordinator. I am also the Chair-Elect of the Michigan Coalition of Healthy Mothers, Healthy Babies, mother of two and a nurse who's mission in life has been directed toward advocacy for women and children.

As the saying goes, "You are who you hang around with" and I am fortunate to have associated with many individuals of vision who have done good work on behalf of those that are underserved and impoverished. This work is frustrating because I live in a society which has valued issues related to military initiatives at the expense of human services. At the forefront of this disease in our society is that seemingly we have not valued our heritage (our elders) or our future (women and children). I am often reminded of a now famous caricature which depicts the pirate ship of the Federal Government and individuals walking the plank with the caption "Women and children first."

I also live in a society which for the noblest of reasons has embraced the notion that we are all created equal and are entitled to the best that health care can deliver. This notion is filled with deceit and prejudice, however subliminally or overt. I am afraid that I live in a society, which, until the priorities on a National level reflect humanism and not militarism, is buckling under the pressures at hand.

I see diversification as a major problem. We have tried to divide the spoils, so to speak, on unsuspecting shoulders hospitals, taxpayers, bureaucracies, the medical profession, etc. Maternal child health has long operated under the philosophy, "Let's rob Peter to pay Paul." The result is the cannibalization of Maternal Child Health Programs, the territorialization of the Federal vs. State; DSS vs Mental Health vs. Public Health vs Environmental Health, etc.

Let me further clarify my world, the world of rural health in Northern Michigan. We reflect the reality of Rural Health in America. Categorically, we have major problems associated with: access to car, geographical maldistribution of human resources, maldistribution of health care institutions, inadequate services, little public

transportation in a vast geographic area, a population disproportionately poor and poorly educated who are trying to survive in a world that is economically depressed.

I live in a world of vast contrasts: the "haves" and the "have-nots". My family lives in a community which is the recreational haven for many of the country's super wealthy. They are not so affectionately known as the "summer people." They are in contrast to the pockets of frankly impoverished Northern Michigan folks who live here either because "they always have" or because they value the spiritual beauty of that which is "the North Country," or because they are Indigenous People of Chippewa-Ottawa Tribes.

Our reality mirrors the haunting figure of well over 30 million uninsured citizens, 60 percent of whom work or are dependents of workers and 1/3 of whom live in poverty. Forty percent of those impoverished are children is indeed our reality. Eighty percent of our catchment area income is less than \$25,000. If one corrects for the affluent areas in Petoskey and Charlevoix, that number increases geometrically. Thirty three percent have no high school education. An inordinate percent are seasonally and sporadically employed in the service industry barely able to keep their heads above water, let alone have health insurance.

Northern Michigan Hospitals is charged by the State Department of Public Health to serve the high risk perinatal needs of the northern portion of the lower peninsula and the eastern end of the Upper Peninsula, including three islands, Mackinac, Drummond and Beaver. Besides the obvious geographical barriers, the providers are maldistributed. There are many counties which have no medical care providers for prenatal care. District 3 Public Health is approaching us this week because yet another county is without prenatal care providers.

Philosophically, Northern Michigan Hospitals has accepted the burden of providing care for those patients; the number of clients who we serve who are uninsured is rising each year and our Medicaid rate is 33 percent. This is particularly crucial in that we suffer from small numbers disease' or low volume which is particularly sensitive to low reimbursement.

We have developed an innovative approach to prenatal care, Shared Care. This program is intended to help provide prenatal care to physicians who for differing reasons no longer provide delivery service. We have had two hospitals close in the near past, and another hospital cannot provide ongoing delivery service. These are not hospitals across the street, they are hospitals on Lake Huron and across the bridge. As it is, 20 percent of our deliveries are from the Upper Peninsula, anywhere from 45 minutes to two hours away.

Many times we, by virtue of our geographic location are involved in rendering ultra high risk care because the client can not or will not allow transfer to down-state Perinatal Centers. Recently, a single, 19-year-old Medicaid patient required an ICU nurse, special OB nurse, anesthesiologist, cardiologist, NICU nurse, pediatrician and obstetrician to facilitate a safe delivery in our Intensive Care Unit.

The outreach that is provided to keep health care practitioners up to date are supported by a small grant from MDPH. They cover about 10% of our actual costs. The Governors Task Force on Regionalization of Perinatal Care is attempting to address many of these related problems.

Access issues are not limited to lack of public transportation, vast geographic area, lack of medical support of prenatal care, and hospitals, they are also obvious in support services such as Mental Health. There is not another Infant Mental Health Specialist north of Kalkaska. The Mental Health services which serve the northern portion of the Lower Peninsula only provide crisis intervention to a minuscule number of clients. It was reported to me that 90 percent of the energy goes into 5 percent of the chronic population. It was further reported that insufficient or unmet needs had currently been recognized in somewhere in the 40 percent ball park. They do not have the capacity to service the need as it exists today. Transportation is clearly a barrier to care. Provision of dental care to the underserved or unserved is also a clear problem. The bureaucracy of eligibility is also identified as a barrier. We were eagerly anticipating the initiation of Infant Support Services to augment the Maternal Support Services, but due to fiscal constraints on DSS and the budget appropriations process, it was put on hold.

The following programs, known to be successful, are extinct or endangered: outreach for maternal child health, availability of providers, production of vaccines, general fund support for WIC, the Michigan Health Initiative (AIDS and Minority Health), family planning services, inspection for child foster care and child care centers, paraprofessional outreach and initiatives to train certified nurse midwives and physicians for rural underserved areas.

Increasing eligibility for the uninsured and underinsured children is much like deciding to accept a new roof with sunlights for your old farmhouse. It would be

great to let some sunshine in for the health of your family members—but the very foundation of your home is crumbling before your eyes.

It is clearly a humane and moral act to address the needs of the underserved and unserved. Further, there is no more noble act than to value our women and our children.

Increasing eligibility, though moral, will concomitantly increase the danger of drowning in the quicksand of healthcare provision of the impoverished. The weak yet wholesome voice of the needs of our rural populace clearly yields to advocates such as those of us in these halls.

PREPARED STATEMENT OF MARVIN MCKINNEY

Mr. Chairman and members of the United States Senate Finance Subcommittee on Health for Families and the Uninsured, as the Director of Planning and Community Affairs at the Mott Children's Health Center in Flint, Michigan, an adjunct instructor at the University of Michigan-Flint in Health Care Research and Evaluation, a founding member of the Black Health Advocacy Forum of Greater Flint, and a member of the Michigan Council for Maternal and Child Health, I wish to thank you for this opportunity to serve as an expert witness on the health conditions and problems of African Americans with particular reference to that segment of this population within 150 percent of poverty. I especially want to thank you for having the vision and insight to not only seek an understanding of the plight and crisis experienced by a large segment of our urban population but to go even further in your quest by examining the peculiar institutional behaviors that often times results in a lack of sensitivity to a most proud and most vulnerable group of human beings.

It is especially important that it be noted for the record that I as an "expert" am all too aware that although I pride myself on my scientific training both at the University of Michigan and the University of North Carolina at Chapel Hill, I am a Black man socialized in America and thus historically I submit that I have been a "participant observer" that often times over rides my academic training.

My comments will be directly related to the African American community in Flint, Michigan, however, I submit that any community of color with the indicators of a high rate of unemployment, a high rate of incarceration, a financially strapped public school system and a high rate of infant mortality will also reflect similar trends.

In 1939 Gunnar Myrdal wrote a sociological treatise titled The American Dilemma. This document spoke to the conflict between our national values of democracy and the national behaviors and policies directed at African Americans. How could we profess to honor freedom of speech and opportunity when it was denied to so many was the premise question. Later, James Baldwin wrote a novel that became very popular in the late 1960's, it was titled Another Country. In it he described the world of Black America which was very different from the experiences shared by the majority culture. The contrast between African and White Americans is even more evident when one reviews the health statistics of the present time.

I would like to reflect on some of these data as they are reflective of the community in which I work. The data which I will be using come from a Mott Children's Health Center sponsored study prepared by Dr. Kurt Gorwitz and myself.

One out of fifteen of Michigan's 1.3 million black residents lives in Genesee County and they constitute 20 percent of its 440,000 population. Only Wayne County has a greater number of proportion of black residents. As in much of the rest of the state, Genesee County's black population is in an ongoing transition with a widening separation into two primary groups based on socioeconomic status.

SELECTED STUDY HIGHLIGHTS

Projections based on U.S. Census estimates indicate that Genesee County currently (1988) has 86,000 black residents, 20.2 percent of its population. As detailed in the subsequent text.

1. One out of six (about 14,000) black residents has no health insurance, 26.5 percent have Medicaid and/or Medicare coverage only, while 57.5 percent have private insurance such as Blue Cross-Blue Shield. A small number have Medicaid and/or Medicare in conjunction with a secondary private policy.
2. One of seven black babies weighs less than 2,500 grams (5 pounds 8 ounces) at birth compared with one of 20 white babies. On the average, black babies weigh 200 grams (0.4 pounds) less than white babies at the time of delivery.

3. A black baby now is three times as likely to die in infancy (the first year of life) as a white baby. The black infant death rate rose from 19.2 per 1,000 in 1980 to 25.3 in 1987 while the white rate decreased from 11.7 to 7.7.
4. One out of five black infant deaths is due to reduced length of pregnancy and/or low birth weight. Only 11.4 percent of white infant deaths resulted from this factor. The primary cause of black infant mortality, respiratory distress, commonly is related to premature delivery also.

These statistics only tell a quantitative outcome part of the story, they do not speak to the antecedent underpinnings of people who live in poverty and their relationship to the foreign system of health care. We don't expect the dastardly statistics to be changed any time soon, some of the antecedents to the problems are so deep seeded that an evaluation design that does not target across generational change may be unwise. The problems are not intractable but they are multi causal and multi faceted, and must be attacked through those institutions that have authenticity and credibility in the black community.

Each year at Mott Children's Health Center in Flint, we provide service to approximately 20,000 children who are within 150 percent of poverty. Of those 20,000 approximately 5,000 are medical patients and a similar number are dental patients. Approximately 25 percent or 5,000 of all of our patients have no insurance coverage and about 60 percent or 11,000 are insured by Medicaid, the additional 15 percent have some type of insurance but we usually "absorb" the deductible ourselves which in some instances is as high as \$500. We do not charge patients any fees.

Last year our medical department returned 25 cents on each dollar it spent. We also see approximately 5,000 clients in our behavior department who need psychological support for which there is even less reimbursement. So, the level of reimbursement is a major problem for providers of care to low income people. In Kalamazoo, Michigan within the last month a major hospital clinic closed its doors to 3,500 Medicaid recipients because it could not maintain itself on the level of Medicaid reimbursement. Two perfect examples of this at the Mott Children's Health Center are the cost of doing a pediatric physical examination is \$25-30, Medicaid pays us \$11-12. In the dental department to do a screening which includes a prophylaxis, and two x-rays costs us about \$55-60, Medicaid reimburses us \$22.

The Michigan Council for Maternal and Child Health has gone on record in supporting expanded services and access to care. Unfortunately without the necessary resources, this becomes a false promise.

So, you see that Medicaid can be construed as a "false promise" because for some clients and some providers, it is a promise that can't be kept. The "Council" has also expressed that the health care delivery system for specific and culturally diverse populations must be designed to expand access and support providers in promoting non-traditional prevention and treatment programs that are respectful and understanding of the recipient's environment. But even if the program was fully funded, barriers to care would still exist. I hope that the following examples will illustrate my point.

Most black low income people in our city are isolated and invisible to the power people who make decisions about how they shall live and what services they will receive. Even the most sensitive of this power group has no direct contact with the most vulnerable among us. It is business as usual or policy from a distance.

At the Mott Children's Health Center, it is not unusual for an appointment to be broken at our Center. As a matter of fact we have a consistent 30 percent no show rate over time and even though we attempt to remedy this by "over booking." This clearly is not the only answer. In 1987, we conducted a "no show study," that has helped us modify a number of our patient service policies. We asked generically, 'Can you share with us why you did not keep your dental appointment.'

The most noted responses were, -lack of reliable, dependable transportation; -inconvenient clinic hours, especially for the working poor; -lack of safe access to a telephone to cancel the appointment; -a family emergency that took precedent over the appointment; -perceived lack of sensitivity regarding adolescents, race, poverty.

In one case a mother shared with us that she wanted to keep her appointment but it was cold and snowing outside, she had no one to watch her sick child and she was afraid to walk to a telephone booth. In another example a mother and her two children were getting ready to board a bus and were accosted by a person carrying a gun who wanted money.

Most clinics in our area, save emergency rooms, have operating hours of 8-5. For a working poor family, it means that they would have to forego a day's pay to make a clinic visit. This is a most precarious decision to make.

In Flint, like many other cities the health care treatment system is predicated on people who have ordered and predictable lives. It is predicated further on people who are future oriented and seem to feel that they have control over their lives. This is not always the case for low income households especially when the household is headed by a single, adolescent mother who resides in a community where turbulence and violence can emerge at any time. Any health care access project must understand that there are certain barriers to health care irrespective of the size of the funding source and allowances must be built in to the legislating policy. My overall assessment of the continuity of health care policy for low income people is that it should be redesigned to reflect the needs of the people for whom it was intended.

To the Subcommittee, I offer the following recommendations:

- . The reimbursement rate for medical services rendered should be reflective of the actual cost.
- . Financial incentives should be available to providers for offering services with extended and week-end hours.
- . Provider clinics should be expected to have a minimum of 50 percent of its clients to be "walk-ins."
- . Transportation cost should be covered for families, especially those in need of emergency care.
- . Provision and reimbursement for mental health services without a psychiatric oversight should be a part of the reimbursement service package.
- . Financial incentives should be available for the treatment of multi-problem families, inclusive of parent education and health education.

Health services should be placed in the communities with other human service agencies to promote "one stop shopping" and promoting a community safety zone such as public schools with declining enrollment. Most importantly, community leadership must somehow be built into the reimbursement mechanism to assist in ongoing community involvement and empowerment.

Plain and simple, if we do not begin thinking and understanding the multiple, deleterious and injurious aspects of the inner city we will most assuredly lose at a minimum, two generations of human beings. We lose them to drugs, premature parenthood, violence, imprisonment, infant mortality, unacceptable social and emotional behavior, and perhaps most dastardly — with recalcitrant and punitive social and public policies that will be designed to control and contain rather than to support and ameliorate the problems.

I would like to close by saying - relative to health no variable is more predictive than income and appropriate insurance coverage. The connection between race, poverty, and rotten health outcomes cannot be denied. The extent to which such outcomes are predictable and not random is the extent to which we must alter our traditional perceptions of health care delivery.

Once again, the Black Health Advocacy Forum of Greater Flint, the Mott Children's Health Center, and the Michigan Council for Maternal and Child Health would like to thank Senator Riegle and the Senate Subcommittee for this opportunity to present these views.

PREPARED STATEMENT OF IRMA REDDEN

My name is Irma Redden. I am a single parent currently employed with a small trucking company in Dearborn. I am here today to testify about the problems I have had in obtaining health insurance for my son, Eddie.

When Eddie was two years old, he was diagnosed as having Cerebral Palsy and a learning disability. Cerebral Palsy is a disabling condition that causes loss of control over voluntary muscles. Eddie looks like a normal 4 year old boy, however, he actually functions like a 2½ year old. Children with Cerebral Palsy often fall because of their poor muscle coordination. Therefore, I worry about him when he plays because there is always a chance he could get hurt.

Like any concerned parent, I want to get my son covered for insurance. I realize the cost of prescription drugs or a visit to the doctor or an emergency room would be astronomical. That is why, in August of 1989, I asked my employer to help me get insurance benefits. He agreed and took quotes from John Alder Insurance Company. The agent representing the company assured me, that Eddie and I would both be covered under their Preferred Provider Organization of Michigan. He gave me the personal enrollment form and told me to fill it out.

The personal enrollment form asked for many details including a health history of Eddie and me. One of the questions asked was if either of us had been treated for a physical disorder or deformity. I answered yes and explained the particulars of Eddie's condition on the reverse side. I also explained that Crippled Children's Program, a state organization which provides financial assistance to families of children who have handicapping conditions, picks up any extra expenses related to Cerebral Palsy. When I say extra expenses that means therapy, orthopedic doctors, neurosurgery, etc.

The next month, I received a letter from the insurance company stating that I had been approved for health benefits and that Eddie had been denied due to the fact that I admitted he had Cerebral Palsy. When I heard this news, I was extremely upset and contacted their Underwriting Department to find out more about Eddie's denial. I was told that if I had been employed by a larger company, then Eddie's health history probably would have slipped through and he would have received coverage. I was very irritated because they didn't pay any attention to Eddie's actual medical history to find out that he is a healthy child, not prone to accidents or illnesses, or to the fact that Crippled Children's picks up all the extra charges related to his disability. If they had explored his case a little further, I feel we may have received fairer treatment. At this point, I was totally frustrated and contacted my caseworker at Crippled Children to explain the problem. She referred me to the United Cerebral Palsy Foundation. I had contacted them in the hopes that they would be able to provide me with some assistance. I soon found out that I was not the first person who contacted them with this problem. Apparently, several parents with handicapped children are faced with the same difficulty of finding no health insurance. Because these cases are based on discrimination, the Foundation is thinking of filing a law suit. However, at this time, they could only promise to contact me if they ever decided to do so and provide me with further information. Even though I was upset about not going to battle with the insurance company, I was relieved to know that there are people aware of the problem and I remain hopeful that one day the system will be changed.

My next step was to contact a social worker at the Henry Ford Foundation, who eventually led me to you. We were trying to see if Eddie would be eligible for Supplemental Security Income—a program of last resort for people who need cash assistance and health care benefits. Unfortunately, I received a denial from them which stated that, because of my income, Eddie did not meet the eligibility requirements. However, if Eddie ever fell down and broke his arm, I could take him in for emergency treatment. This would include a one time visit only; no follow-up visits would be covered.

So currently, Eddie remains uninsured. I have received quotes from other insurance companies but they are much more than I could ever afford. Furthermore, I have been told that even if I could pay for it, I would be denied due to Eddie's condition.

I only make enough money to make ends meet. At this time, my salary doesn't allow me to save for unforeseen expenses. So when Eddie needs to go to the doctor it comes right out of the money we use for groceries or daily living costs. For example, last year Eddie had an ear infection and needed to be seen by a doctor. The office call was \$25 and the antibiotic was another \$25. Because I paid for the visit that same day, I didn't have enough money to pay for our phone bill and it was discon-

nected. In addition, we had to use part of our grocery money for the balance of the bill.

In closing, I want to say that I am upset that I can't insure my son. I want to be able to take care of him when he gets sick or injured. I want to have the kind of insurance policy or income that would enable me to seek treatment for Eddie without having to spend money that should be used for our groceries or other living expenses. I will never neglect his need for medical treatment; however, I live in fear that some day something will happen to Eddie and I won't be able to take care of him.

Thank you for allowing me to testify.

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

Good Afternoon. Thank you for coming to this official hearing of the Finance Subcommittee on Health for Families and the Uninsured. Today, we will hear about the problems our most vulnerable citizens—our children—face in obtaining health care. It's a national tragedy that over 12 million children, close to 300,000 in Michigan, have no health insurance.

We will hear testimony from families with children who do not have health insurance, and providers and advocates that are desperately trying to meet the needs of children in Michigan. I welcome others to submit their testimony in writing or orally to my staff. All testimony will be included in the official transcript of the hearing.

This hearing is titled "Health Care for Children: Protecting America's Future"—and for good reason. Recent trends tell a very disturbing story about how we as a nation care for our children.

While the U.S. has the most advanced and sophisticated health care system in the world, one in five children have not a penny of health insurance. The many faces of these uninsured children, as we will hear today, raises important questions about our current health care system.

As these charts show, forty-one percent of uninsured children, 5 million, live in families with incomes below the Federal poverty level. Clearly, our nation's public program, Medicaid, is an inadequate safety net for low-income children; covering only 50% of children below poverty level. But many uninsured children—30 percent—live in middle income families as well.

Many children are also falling through cracks in our employment-based system of health care. Three-fourths of uninsured children live in working families. In these cases, the employer does not provide insurance, or it is not affordable. Other children have no access to care because they have a preexisting medical conditions and are actually excluded from coverage.

The impact of this lack of adequate care is reflected in key health indicators. The U.S. continues to have one of the worst infant mortality rates—ranking 18th among industrialized countries. This is particularly alarming since these deaths are preventable. Though prenatal care is one of the most cost-effective ways to spend health care dollars, one in three pregnant mothers receive inadequate care in Michigan.

Overall, the United States has far to go but some regions face even greater problems. In Michigan, although the infant mortality rate of almost 11 (deaths per live births) is consistent with the national average, Detroit's rate is over 20, almost twice the rate of the nation. And Genesee county has a rate of close to 15.

Our children are simply not getting the care they need and deserve. For example, millions of children fail to receive routine immunizations against preventable disease such as polio, measles and the mumps. This is very costly to society in both human and economic terms. \$1 spent on immunizations saves \$10 in future health care costs. We do not have this money to waste, when millions of children do not have health care. This is especially relevant in Michigan which has experienced 220 report cases already this year, with one death. The Senate passed a final dire emergency Appropriations bill with \$35.5 million for immunizations, that is expected to be signed into law soon. But more must be and can be done.

Other barriers to health care exist as well. Lack of providers is a key problem in rural areas. Many providers also choose not to participate in Medicaid because of the administrative difficulties and low reimbursement rates. The complicated enrollment process itself is a barrier for people needing health care. We also have inadequate outreach programs to bring families into our health care system.

Our current system clearly needs to be reformed. As a nation, we must provide adequate and affordable health care for our children. The needs of our children should be a force for change.

Until we address the problem of providing comprehensive health care for all Americans, efforts that focus on improving the current delivery of maternity, infant, and child health care in the U.S. are critical.

As Chairman of the Finance Subcommittee on Health for Families and the Uninsured, I have introduced legislation to continue work last year to improve health care coverage for low-income pregnant women and children. The Medicaid Child Health Act includes over 15 provisions that expand Medicaid eligibility, and improve benefits and the delivery of health care services. I am also working to increase funding for the Maternal and Child Health Services Block Grant by \$125 million. This program provides funding for health care services including immunization and prenatal care.

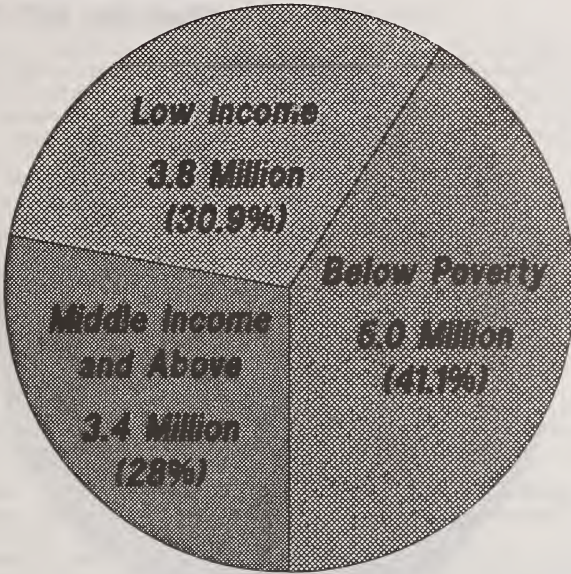
Health care for children is one of the most important aspects of our efforts in the Senate to provide universal access to health care for all Americans. I am leading a bi-partisan Senate Working Group that is developing comprehensive legislation to provide quality, affordable health care to all Americans. This Subcommittee has held several hearings in Michigan to learn of the problems of people who have no health insurance coverage. Hundreds of people have attended to hear testimony from uninsured people, business and government leaders and providers.

With the information gathered at these and other hearings in Washington, we are well on our way toward developing a comprehensive legislative solution to this tragic problem. We expect to have a proposal developed within the next few months. My Subcommittee plans to move legislation this year.

If our children are to have a chance, they need to be healthy. America's children represent our future and we need to protect that future. High quality, affordable, health care for all Americans is one of my top priorities in Congress—and together we can see that this happens.

Attachments.

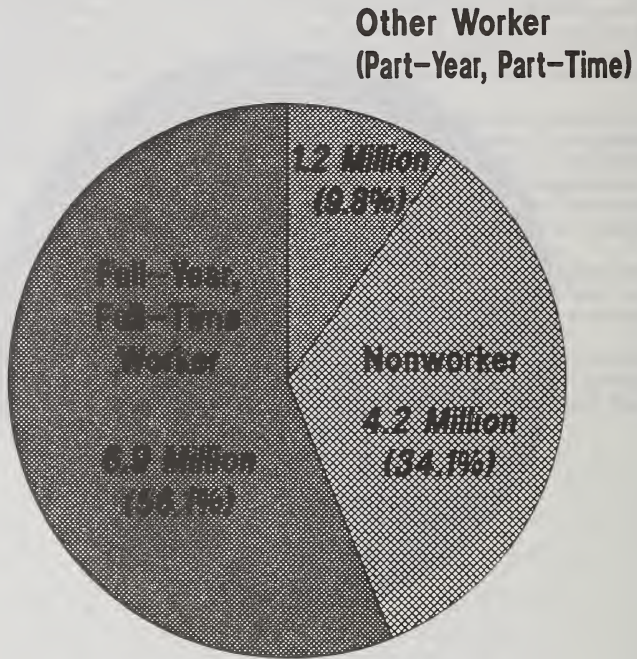
Family Income of Uninsured Children Under Age 18



12.2 Million Uninsured Children

Source: Employee Benefit Research Institute

Uninsured Children Under Age 18 by Head of Household Employment Status



12.2 Million Uninsured Children

Source: Employee Benefit Research Institute

KEY PROVISIONS OF MEDICAID CHILD HEALTH ACT (S. 2459)

EXPANDED MEDICAID ELIGIBILITY

Optional coverage of children with incomes below 185% of the poverty level up to age 19. States would also have the option of setting separate age and income thresholds, or expanding eligibility only for foster care children.

Phased-in coverage of children up to age 19 in families with incomes below the Federal poverty level. States would be required to phase-in coverage of children below 100% of poverty a year at a time, starting with 6 and 7 year olds in 1991. All children under the age of 19 whose family incomes are below the Federal poverty level would be covered by the year 2002.

IMPROVED MEDICAID BENEFITS

Payments for hospital services. Payments for children in hospitals serving a high volume of Medicaid recipients and infants in any hospital would no longer be subject to limits on the number of days of paid coverage. Additional payments for exceptionally severe patients would be required in those states that pay hospitals on a prospective basis. Dollar limits could not be imposed on stays for infants admitted to the hospital.

Optional Home and Community-Based services. States would have the option of providing home and community-based services under Medicaid for children with AIDS and children who are ventilator-dependent.

Optional Coverage of Home visitor services. States would have the option of providing physician-prescribed home visitor nursing service for infants up to 6 months.

Optional Coverage of Outreach Services for Pregnant Women and Infants. Outreach services to assist pregnant women and infants in applying for Medicaid would be made and optional service under Medicaid.

ADMINISTRATIVE AND OTHER IMPROVEMENTS

Continuous eligibility. Pregnant women would be Medicaid-eligible for 60 days after delivery. Children would continue to be Medicaid eligible until the state determines that the child is not eligible under any rules. Eligibility redetermination would be limited to every 6 months for children up to age 6.

Limit asset test for pregnant women. In determining eligibility for pregnant women, states could not count the value of an automobile, personal effects, household goods, life insurance or a burial plot.

Use of Most Recent Data in Calculating Federal Matching Percentage. Annual matching rates would be recalculated in April rather than the previous October, to more accurately reflect the current condition of the state's economy.

SENATOR DONALD RIEGLE, JR., CHAIRMAN, FINANCE SUBCOMMITTEE ON HEALTH FOR FAMILIES AND THE UNINSURED

LEGISLATIVE ACTIVITIES

Background on Subcommittee

The Senate Finance Subcommittee on Health for Families and the Uninsured was created in the 101st Congress, in 1989, at the request of Senator Donald W. Riegle, Jr. Senator Riegle wanted to bring attention to the problems of people without health care coverage and to develop a solution to this pressing national problem.

In addition to the problems of the uninsured, the Subcommittee has jurisdiction over Medicaid, the Federal and State program providing medical assistance to very low-income people, and the Maternal and Child Health (MCH) Services Block Grant which provides health care services to mothers and children.

Medicaid

Senator Riegle recently introduced with Senator Bentsen, the Medicaid Child Health Act of 1990. The bill has over 15 provisions that would expand Medicaid eligibility and improve the benefits and the delivery of care to children. A summary of key provisions in the bill is attached.

Last year, Senator Riegle worked to expand and improve administration of the Medicaid for pregnant women and children. A key provision was expanding Medicaid coverage for pregnant women and young children with incomes up to 133% of the Federal poverty level. An estimated 90,000 pregnant women, 70,000 infants, and 700,000 children nationwide are eligible for health care services under this new law.

Maternal and Child Health (MCH) Services Block Grant

Riegle is also working to increase funding for the MCH Services Block Grant program by \$125 million. The program gives states funding for services to children and pregnant women, including prenatal care and immunizations. The state of Michigan could gain as much as \$4.6 million if the increase is approved.

Last year, Senator Riegle worked to re-structure and reform the MCH Services Block Grant to enhance accountability and more effectively target areas of greatest need.

Uninsured

Since 1989, the Subcommittee has held hearings on the uninsured including two in Washington and two Michigan. Hundreds of people attended the hearings in Michigan where the Subcommittee heard testimony from uninsured people, Business and Government leaders and providers on the problems of people without health insurance.

At the June 1989 hearing in Washington, Senator Kennedy, Chairman of the Labor and Human Resources Committee, testified and in an unprecedented move the two Chairmen agreed to have both Committees work together to develop legislation on this problem.

Since that time, Senator Riegle has organized a bi-partisan Senate Working Group with 15 members of the Finance and Labor Committees to craft a legislative solution to the problems of 37 million Americans without health insurance and the problems of rising health care costs in this country.

The Bi-committee, Bi-partisan Senate Working Group released a document of the options under consideration, including the recommendations of the Pepper Commission, for public comment in March. In developing the bill, the Working Group plans to use the recommendations of individuals and organizations having an interest in health care issues. Senator Riegle plans to develop legislation this year.

PREPARED STATEMENT OF CHRIS ROSEBUSH

My name is Chris Rosebush. I'm here today with my husband Brian and my two children. Aaron is five years old and Sara is two. The children and I are all insulin dependent diabetics, so good medical care has always been a necessity. But unlike most American families, we are not able to go to the doctor or hospital whenever we think it is needed. Because we are unlike most other American families, we have no health insurance.

At one time, we didn't have to worry about having health insurance for our family. My husband Brian had Blue Cross at his place of work. He was employed there for six years and during that time, Blue Cross paid for my children's birth and their stay in ICU afterwards. There were a few times when Aaron and Sara had to be hospitalized during infancy, but knowing we were covered by insurance took some of the strain off me and my husband.

But three years ago Brian lost his job. Our Blue Cross was gone as well. Luckily, the children were able to qualify for the State's Crippled Children's program. However, this covers only expenses for Aaron and Sara's diabetes, nothing else.

Brian has found another job working full-time as a waiter. We thought we would receive hospitalization coverage after one year but they ended up not offering health benefits. I have tried to buy coverage from other health insurance companies but the premiums were much too high for our family. Companies wanted over \$700 every three months. Even if we could afford that kind of payment, when companies find out we have diabetes, they don't want to cover us.

I've also applied for assistance from the Michigan Department of Social Services. We were finally told that the children qualify for Medicaid coverage, but only after we spend about \$1600 per month out of our own pocket. But we certainly cannot afford to spend \$1600 per month in medical bills for the children. So, the only way we would benefit from Medicaid coverage is if one of the children has to be hospitalized and the bill costs over \$1600. Then Medicaid could help but we'd still be responsible for the \$1600 per month.

In the meantime, we must pay for all our health care out of our own pocket. My son Aaron had to have minor surgery on his mouth not long after my husband lost his job. We still had Blue Cross but our coverage was about to end. The oral surgeon wanted \$200 up front. My parents were there to help loan us the money. We thought everything was fine until after the surgery the doctor wanted more money. With no job and a little bit of unemployment coming in for my husband, we were not able to pay. The doctor turned us in to a collection agency. Our total now in

medical bills is over \$1000. That doesn't count the money we pay for the walk-in clinics either.

I myself have been diabetic since I was 6 months old, but it has been years since I've been to the doctor for care. I just got the flu so bad that I needed a doctor. I got turned down at offices because I have no insurance so my father took me to his doctor. The doctor told me I should be hospitalized, but with no health insurance he did the best he could do. Every day, I worry that the same thing will happen with Aaron or Sara.

My husband is looking for a different job with health insurance. He was recently in the final ten for a factory job. It had excellent health benefits, but he didn't get the job. So he continues to look and we continue to worry that if Aaron or Sara get sick, we might have no place to go for health care.

I have looked so hard to find help for my children and to be turned down has put a terrible strain on my husband and me. We fear one of us will need a hospital and be turned down. Our children need the best of care but our money isn't enough. We know we're not alone and that many others are in the same situation. We need to band together and stand up to be heard.

PREPARED STATEMENT OF THOMAS M. ROZEK

My name is Thomas M. Rozek. I am President and Chief Executive Officer of Children's Hospital of Michigan, in Detroit. With me is Dr. Sheldon Brenner, Director of Ambulatory Pediatrics at Children's. Children's is a 290 bed, non-profit pediatric hospital treating diseases and disorders of children from birth through the age of 18. In 1989 Children's had approximately 12,000 inpatient admissions, more than 91,000 outpatient visits and over 60,000 emergency room visits. We are the primary pediatric teaching facility for the Wayne State University School of Medicine in Detroit and the major pediatric referral center for southeast Michigan and a substantial portion of the entire state of Michigan.

I appreciate the opportunity to appear before you today to address issues and concerns regarding the medical care of uninsured and underinsured children.

The National Association of Children's Hospitals and Related Institutions, or NACHRI, has undertaken a year's study of Medicaid coverage of poor and near-poor children. Their preliminary findings indicate that access to care for children of low income families through Medicaid is a function of four issues: eligibility, enrollment, services and reimbursement.

In 1989, NACHRI conducted a snapshot of children without health insurance. Twenty-two children's hospitals from around the country collected data for one month on every child admitted to their institutions with 110 health insurance.

Children's Hospital of Michigan was one of the twenty-two participating hospitals. During that one month of study, seventy-three children were admitted to the hospital with no health insurance. Fortunately, however, the state of Michigan has a medically needy program, wherein, if a family is faced with a catastrophic expenditure for health care, the family can become eligible for Medicaid. Thus, of the seventy-three children uninsured upon admission to Children's Hospital, only nine have resulted to date with no insurance whatsoever. While this is good news in terms of creating greater eligibility for hospitalized children, two problems remain:

1. For some, especially, those enrolled through the medically needy program, once enrolled, eligibility is redetermined every month rather than every six (6) months or one year for those categorically eligible. This means that after one month, the child no longer has insurance to cover normal outpatient care and must wait for the next hospital episode to be eligible for Medicaid again.

2. Secondly, the mere eligibility of the child for Medicaid does not ensure enrollment, and certainly does not ensure adequate payment to the Hospital or physician by the state Medicaid program.

Fortunately for all children, you, Senator Riegle, along with your colleagues, Senators Bentsen and Chafee, have introduced Senate Bill 2459, the "Medicaid Child Health Act of 1990." This Bill, if enacted, would significantly improve eligibility standards for children across the country by requiring Medicaid eligibility for those younger than the age of nineteen (19) years in families with incomes below the Federal poverty level.

The second major area of concern to children's advocates when discussing children's health care is the enrollment process for Medicaid. According to a study sponsored by the Southern Governor's Association, an average of one-third of the people who applied for aid to families with dependent children or Medicaid assist-

ance were disqualified—not because they were ineligible but because they were unable to complete the application process. In the state of Michigan, the Medicaid enrollment form is twenty-three pages long, and requires the inclusion of a significant number of supporting documents in order to be approved by the state Department of Social Services. While we do not believe this is done for nefarious purposes, non the less it is a significant inhibition to individuals and families who are more worried about their hospitalized child or the source of their next meal or drug fix than whether or not the hospital is paid for providing services. In 1989, Children's Hospital of Michigan wrote off 5.6 million dollars in totally uncompensated care (which is sometimes referred to as bad debts). A large portion of that number is due to parents unwilling or unable to complete the Medicaid enrollment form.

Again, Senate Bill 2459 will significantly improve the enrollment provisions of Medicaid by providing states the option to grant presumptive eligibility to pregnant women and with provisions regarding continuous eligibility for Medicaid eligible pregnant woman for sixty days after delivery. A key provision is that children would continue to be Medicaid eligible until a state actively determines a child not eligible under any rules.

The third significant area of concern is the benefits available. Generally states will limit their coverage of services in two ways, one by denying coverage for certain specific services, or two, by limiting the volume, duration or total payment for covered services. While this is a significant problem in a number of states, fortunately, the state of Michigan has an extremely broad benefit coverage, and does not limit payment to providers through the benefits structure. They do limit payment, but it occurs through the reimbursement process.

Nevertheless, Senate Bill 2459 will improve availability of services in Michigan as well as the balance of the country by giving states the option of covering home and community based services under Medicaid for children with Aids and ventilator dependent children. Further, the Bill would prohibit other states from imposing durational limits on payments for medically necessary treatment of children under the age of nineteen.

Finally, the fourth significant area of concern is reimbursement restrictions. On the average across the country, children's hospitals are reimbursed approximately seventy-five cents for every one dollar actually spent on the care of indigent children. Even in Michigan, where Children's Hospital of Michigan is granted reimbursement improvements in recognition of the difference between a children's hospital and a community hospital's pediatric unit, we are, nevertheless, significantly underpaid for the care we provide to Medicaid patients. In addition to the loss from bad debts stated earlier, in 1989 we were *under* compensated 5.7 million dollars by Medicaid; and I haven't even begun to talk about our physicians yet. While Senate Bill 2459 will not significantly change the situation in the state of Michigan, it will provide substantially improved reimbursement for children's hospitals in other states.

We have spoken about hospitals and their problems with Medicaid and uninsured patients. Let us spend some time now discussing the patients' and physicians' problems. Children's Hospital recently surveyed 96 pediatricians in Wayne, Oakland and Macomb Counties. Included in this survey was a question on whether the pediatrician was accepting new Medicaid patients. Eighty-three percent of these community pediatricians said they would no longer accept new Medicaid patients. Thus, Medicaid and uninsured patients have a significant problem finding primary practitioners to provide normal well baby care for their infants and children. This results in a medical experience based on episodic care for acute illnesses or for trauma, provided at multiple sites, often at great distances from where the patient lives and often with no transportation, given by a provider who doesn't know the patient and whom the patient does not know, without availability of previous medical records or history. This clearly leads to quality of care problems, time utilization problems, medical liability risks and over utilization.

In contrast, for patients who have good medical insurance or who are capable of paying for ambulatory services themselves, their children are seen by a provider who knows the patient, has the patient's records, is familiar with the family history, accepts appointments for preventive care, and who will see an acute illness on the same day as the parent calls.

The net result is that uninsured and underinsured children are twenty percent more likely to be in poor health, and one-third are not immunized against measles, mumps or rubella by their second birthday, as evidenced by the measles outbreak in various states around the country last year.

Let me document a few reasons for this behavior on the part of pediatricians. Pediatricians generate their income through office visits. They use cognitive and rea-

soning skills, as opposed to performing procedures such as those done by surgeons and other medical sub-specialists. Their office overhead frequently exceeds fifty percent. They can see four to six patients per hour in a traditional well baby practice. Finally, while not paid as much as an internist, or a surgeon or a radiologist for their services, an average reimbursement of three employer based plans in the metropolitan Detroit area would pay these pediatricians nearly forty-eight dollars for a normal office visit.

In contrast, Medicaid and uninsured patients present a complexity of problems that require much more time per patient, resulting in fewer patients seen in an hour, and are reimbursed by Michigan's Medicaid program less than seventeen dollars per visit for the same visit that the average of three programs pays forty-eight dollars. Where would you spend your time?

If the private pediatrician won't see Medicaid and uninsured patients where do these patients go? In 1989, Children's Hospital of Michigan provided in excess of fifteen thousand ambulatory general pediatric visits. Seventy-one percent had Medicaid and sixteen percent were uninsured, resulting in 13,500 of these patients having less than adequate insurance. In addition, Children's Hospital Emergency Room provided in excess of sixty thousand visits in 1989. Of these, seventy-two percent or forty four thousand were of the non-urgent variety which could have been seen in any physician's office had one been available. Of these forty-four thousand visits, forty-four percent were Medicaid, approximately twenty percent were health maintenance organizations which enroll Medicaid patients, and twelve percent were direct, or as we say, no pay.

Finally, Children's Hospital and its medical staff experience what we refer to as quasi dumping. This is the transfer from other general acute hospitals of patients who are experiencing acute abdominal pain, fractures of the long bones, or other maladies, with the justification that no pediatric surgeon or orthopedic physician is available. Yet our experience indicates that the majority of these patients transferred have Medicaid or no insurance, and very few have Blue Cross/Blue Shield or other insurance types.

The future of the United States depends on a healthy, well educated, productive work force. Of those entering the work force, 4.5 million adolescents are uninsured, frequently have untreated chronic diseases, of ten respiratory and emotional disorders. Further, this population is at a high risk for pregnancy and substance abuse. Far too few preventative services and programs are available for teen suicide and teen substance abuse.

There is no debate that Senate Bill 2459 will go a long way toward fixing many of the problems mentioned above. However, as long as we attempt to fix only the Medicaid and poor populations, we will not have universal access unless something is done to assure dependent coverage through employers. The percentage of insured dependents by employer plans is decreasing, as evidenced by the fact that in 1984 thirty-eight percent of employer health insurance plans covered dependents, compared to 1988 when only thirty-two percent covered dependents. Penalties and incentives need to be developed in order to encourage employers to insure dependents. The American Academy of Pediatrics has developed proposals for such a plan, as well as the Bi-Committee Bi-Partisan Senate Working Group on Universal Access.

The noted health care author, Mr. Paul Starr, in comparing the Medicare and Medicaid programs, stated, "Medicare enjoys the political protection created by a span of eligibility that includes the middle class; Medicaid suffers from the political vulnerability created by identification with welfare and the poor. Hospital benefits of Medicare are additionally protected by financing that comes from an earmarked payroll tax, whereas Medicaid must compete for general revenues—at not only the Federal but also the state level." In short, the health care safety net for children is in significant disrepair, and needs not just emergency surgery, but long term permanent rehabilitation. While perhaps not all the answers are included, Senate Bill 2459 includes a significant number of those long term fixes. We applaud and support your efforts, Senator Riegle, and will do whatever we can to assist you in the passage of this important legislation.

In addition, for those who will never be eligible for Medicaid, your efforts on the Bi-Committee Bi-Partisan Senate Working Group on Universal Access will open doors of access for all Americans, particularly the working poor and their dependents.

The biggest problem yet to be dealt with, however, is where will the money come from, particularly in the states which don't have huge budgets to cut.

Charles Stewart Mott, a great philanthropist from your own home town of Flint, Michigan, said, "If anyone is going to do anything on earth to help humanity, doing something for children is a great place to start."

COMMUNICATIONS

RESPONSES TO A REQUEST FOR COMMENTS BY SENATOR RIEGLE

Hon. DONALD RIEGLE, JR.,
*U.S. Senator,
Central Regional Office,
109 West Michigan Ave.,
Suite 705,
Lansing, MI*

Dear Senator Riegle: I attended the hearing "Health Care for Children: Protecting America's Future" at the Lansing Civic Center on May 30, 1990. The testimony made by the individual families and the health care providers affirmed the difficulty we are experiencing in Ingham County.

As a school nurse, one of my responsibilities is to help—families access the health care system for both routine primary care and when an illness or injury occurs. I work with families that have Medicaid insurance and families who have no insurance. In a geographic area that has many qualified health care providers, these families experience great difficulty obtaining quality health care. Very few private pediatricians and family practice physicians in the greater Lansing area are taking *new* Medicaid patients. The pediatric health clinics are overburdened with the demand for services which means a longer than acceptable waiting time for children to be seen.

Recently, I had the opportunity to work with a family that has no health insurance. The young daughter had a strep throat infection that went untreated. A rare complication, Sydenham's Chorea, developed. Although the Chorea should resolve, this condition will need continuous follow-up care.

Many of the children that are on Medicaid come from high risk families that may be more prone to substance abuse, lack of parenting skills, child abuse and neglect. These are families that would benefit by being followed by one health care provider rather than multiple clinics and emergency room visits.

My purpose in writing this letter is to support the Child Health Act of 1991 (S. 2459). As demonstrated by the examples mentioned earlier, the doors are closing on these young children and their families; very few alternatives are available. I would be happy to review any future legislation for children and join in any efforts to provide better health care for children.

Thank you for taking an interest in this area and sponsoring the legislation to make it a reality.

Sincerely,

PATRICIA K. BEDNARZ, RNC, MN

HEALTH CARE RESOURCES,
Lansing, MI, June 4, 1990.

Senator DONALD W. RIEGLE, JR., *Chairman,
Finance Subcommittee on Health for Families and the Uninsured,
U.S. Senate,
Washington, DC.*

Dear Senator Riegle: Recently you held a Senate subcommittee hearing in Lansing to gather information about difficulties in caring for the uninsured children. Participants appreciated the opportunity to express their concerns and frustrations.

I would like to share with you some of my observations and concerns. After spending more than twenty-five years as President and CEO of health care facilities, I have experienced the full gamut of challenges in the health field. During the last two years, I have had a contract with the Michigan Department of Education, Special Education Services, to provide me the opportunity to assist select school districts to become providers of health related services to the handicapped students. We are attempting to access third-party payments, where appropriate, for these services provided by the school districts.

Limited, valuable educational dollars are utilized to provide specific services, such as physical, occupational, and speech and language therapies. Many of these therapies had previously been provided by other agencies. With the increase of the medically fragile child being brought into the educational system, new challenges face the school districts. Subsequently, duplicate systems of service evolve creating an increase in cost, a "buying" of critical medical personnel, development of a competitive model of service rather than a collaborative mode to better serve children.

There is no question that every citizen has a right to access health services. Mandatory coverage for children is critical. Providing that coverage under Medicaid is at least a beginning, even though it has the tendency to become a stigma.

In future hearings or discussions, I urge you to have a representative of special education in Michigan share their problems of providing health services to the handicapped. Is it appropriate for education to be providing these services with education dollars, or should the Department of Public Health and local health departments provide and fund these services?

Insurance coverage will expand the question. If schools are to continue providing health services, parents must be required to allow school districts to access their insurance or entitlements, providing there is no cost to the parents. If this does not occur, there may be double costs: (1) the premium paid by an employer or individual, or the entitlement costs; and (2) the cost of the educational institution providing the health services.

As you continue your all important mission to provide health coverage for uninsured children, remember select school districts who are providing health services to the medically fragile as they are discharged from the neonatal units.

If you or your staff would like to discuss this further, please do not hesitate to call or let me know when you will be in the area again.

Sincerely,

SISTER MARY JANICE BELEN, RSM

A New Vision For A New Century...

Sr. Rita Brocke, R.S.M.
5575 Conner Avenue
2 G05
Detroit, MI 48213

June 17, 1990

Dear Mr. Walker,

I am the family nurse practitioner from Mercy Family Health who spoke to you regarding the need for the children of low income families to have vitamins. I am speaking here about preschool children. Would you please enter this as testimony you are gathering for hearings.

After fourteen years in primary care settings giving care for families, I am suggesting that there is no other more economical, efficient and effective way of improving the health status and



than making available to them vitamins.

This could be done through the Medicaid program as an initial step. The second step would be making the vitamins available to families without health insurance.

Do not be deluded by nutritionists who tell you the children need nourishing food. But they are unrealistic about the availability of nourishing food for poor children. In the absence of proper nutrition, vitamins, at least, give the infant or child a chance of getting a start.

If you need for me to give this testimony publicly, I would welcome the opportunity. Sincerely, Rita Brode, RMC
 Mercy Family Care
 12870 E. Warren
 Detroit, MI 48215
 313-822-5900

United States Senate

WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: LINDA C. CARTER - SOCIAL WORKERAddress: 801 W. M.T. HOPE AVE.
LANSING MICHIGAN 48910Representing: Sickle Cell Detection & Information Program Inc
1800 E. GRAND BLVD - LANSING MI 48909

(313) 485-8769

I invite you to attach a prepared statement or to submit your written

testimony: In working with individuals with a Sickle Cell condition, I have seen far too many not receive the proper medical care due to a lack of medical insurance or financial means to pay for adequate medical services. As Mr. Riegle stated if a small amount is paid into preventive medical care this would indeed eliminate costly hospital care for many individuals suffering from a Sickle Cell condition. I am finding many of my clients falling through the cracks and therefore not living the productive lives that could be if they in fact had the medical care needed.

United States Senate
WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Rev. Clifford A. Beckett

Address: 153 N. Wood St

Little Creek, Michigan
Director Washington Neighborhood Methodist Church

Representing: Director Washington Neighborhood Methodist Church

Ministries

I invite you to attach a prepared statement or to submit your written

testimony: As director of the Washington

w/ Washington Community Ministries I am in contact

with much satisfaction. In the past 30 days

Daily I am in contact with many families

who do not have sufficient insurance or

no insurance, especially pregnant

pregnant mothers. I would like to see that happen

to the best of our citizens programs to us

all - sooner or later. A community or

state or nation that forgets its children

and senior citizens will not last long.

Unless we, as a nation, provide health

care for all our people we are denying

our values - those of us who can afford

health care insurance.

As a modern, civilized, nation, there

is a question as to whether we are really

civilized or we do not decide to be

unfortunate among us, we must
 seek it that our nation's health
 is cared for. Every Child is my Child
 especially if that Child is in need.

I plead with our National
 Law makers to stop playing favorites
 with the lobbyists and get on with
 the business of care for all
 our people especially those who
 can not care for themselves.

Blessings
 Clayton Pullo



**CHILDREN'S HEALTH CARE
OF PORT HURON, P.C.**

1321 Stone Street, Port Huron, Michigan 48060
313/984-1000

DANIEL J. WILHELM, M.D.

DIPLOMATE, AMERICAN BOARD
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JOHN J. ZMIEJKO, M.D.

DIPLOMATE, AMERICAN BOARD
OF PEDIATRICS

SCOTT A. HAWLEY, M.D.

DIPLOMATE, AMERICAN BOARD OF
PEDIATRICS & CANDIDATE, AMERICAN
BOARD OF INTERNAL MEDICINE

SHARON JOHNSTON, R.N.

CERTIFIED PEDIATRIC
NURSE PRACTITIONER

KAY KLYMKO, R.N.

CERTIFIED FAMILY NURSE
PRACTITIONER

June 5, 1990

Donald W. Riegle, Jr., Chairman
Sub-Committee on Health for
Families In The Uninsured
United States Senate
Washington, D.C. 20510

Dear Senator Riegle:

I saw with interest, a copy of a notice you sent to a health worker acquaintance of mine, regarding your hearing May 30th in Lansing concerning barriers to children in receiving basic health care.

I have worked for many years trying to improve access to health care for children, as a community pediatrician here in Michigan. I have long recognized the problem. I have worked for years with the Michigan State Medical Society and it's committee with liaison with the State Medicaid Program, with similar goals to improve access and quality of care for children in the Medicaid Program.

For years we had an almost "open door" policy regarding Medicaid here at our office, as I considered it an obligation as a physician to help the poor. At one time the Medicaid portion of our practice reached almost 30%.

Medicaid has developed various "strategies" to reduce their payments for health care to children, and this has caused a tremendous financial burden and load on the practicing physician. For the past two years Medicaid has required that physicians bill private insurance prior to billing Medicaid, if the family has dual coverage. Many insurances may be in place, but they do not cover office care and we know prior to this billing that we will receive a rejection because office care is an uncovered benefit. Nevertheless we must proceed with the billing of the private insurance, wait for the rejection, and then bill Medicaid for the service. This has greatly increased our costs, and has greatly delayed payment.

Several years ago we could count on receiving approximately 62% of our charges for Medicaid services, but over the past two years the payment has been reduced to approximately 43% of our charges. Our office overhead is 60%. We are unable to continue to subsidize the State Medicaid Program. Other physicians, medical offices and hospitals have also realized the same. Consequently we have had to drastically reduce the Medicaid burden in our office, hopefully reducing it to approximately 10% of our patient numbers. Consequently children are being denied care in their physician's offices, they are having to seek care in more expensive emergency rooms or in outpatient clinics which are not specialized pediatric centers.

I regret the necessity to act in this way concerning Medicaid children, but it is a matter of survival, my personal survival as well as the survival of my practice. We can not afford to subsidize the program and receive payment that is less than the cost of providing the service.

My solutions to "fixing" the Medicaid Program would include:

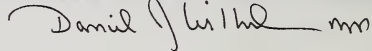
1. Payment of a reasonable fee to physicians providing this service so as to improve access to care for the patient.
2. A program to control utilization of Medicaid services, with a primary care provider determining if special tests, consultations with other doctors, emergency room visits, etc. are necessary. Currently there is no control on utilization and a patient may see a primary care physician in the morning for an earache, see an ear specialist in the afternoon for the same problem, and go to the emergency room later that night for the same problem. Utilization must be controlled and the money saved from this should be put back into adequate reimbursement of physicians and hospitals.

Currently the Medicaid recipient is labeled as a "second class citizen" because they have the Medicaid card when it comes to seeking health care. The government has created a situation in which they are labeled as "undesirable patients". The government should explore other means of managing this program, perhaps a voucher system should be considered.

Currently the burden of Medicaid is placed directly on the provider's shoulders and what ways must be taken to remove this burden so that the conscientious physician can again care for these children. The barriers to do care have been created by the program and the system.

Thank you for allowing me to give my thoughts. I would be willing to discuss this with you, if you have questions.

Sincerely yours,



Daniel J. Wilhelm, M.D.

COUNTY BOARD
Robert H. Craig
Annie Hester

STATE OF MICHIGAN



GENESEE COUNTY
DEPARTMENT OF SOCIAL SERVICES
125 East Union Street
P.O. Box 1620
Flint, Michigan 48502

JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

C. PATRICK BABCOCK, Director

May 30, 1990

U.S. Senator Donald W. Riegle, Jr.
1850 McNamara Federal Bldg.
477 Michigan Avenue
Detroit, MI 48226

Re: U.S. Senate Finance Sub-
Committee on Health for
Families and the Uninsured

Dear Senator Riegle:

The fact that 12 million children nationwide are without health insurance is nothing short of a disgrace, considering the ability of the United States to care for its children. However, health care is but one of many problems plaguing the youth of this country and denying them an opportunity to become useful, productive citizens.

In October 1989, the first National Children's Day Report Card was released in conjunction with the first national Children's Day, October 8 of that year. This document was compiled by Rep. Joseph P. Kennedy II and addresses the current health and well-being of our nation's children. The report assembles a list of 25 indicators which tell how America's children are doing. An advisory committee of twelve professional, reputable persons comment on the indicators which are categorized health, education and welfare. I will use excerpts from the commentary in the report to illustrate:

Dr. Berry Brazelton on Child Health:

."The pockets of failure are predictable--they coincide with the pockets of poverty and of unreachable poor in southern states, and in the ghettos of our cities. In our country those pockets are unacceptable."

Dr. Donald Sheff on Child Health:

."The reality is that child health in America is not what it could or should be and too many children are suffering preventable health problems."

.One of the reasons for this is that children of today do not live in the same world as children of a decade ago. Today's

May 30, 1990

children are poorer, one-fifth live in poverty and 21 percent live in single-parent households. Today, the leading cause of death for children above one year of age is preventable injuries. Reported cases of child abuse and neglect rose a drastic 23 percent in one year from 1985 to 1986. The rates of preventable diseases, specifically measles, mumps and pertussis are all increasing for children under two years old, partly because many parents cannot afford to immunize their children. The result is only 40 percent of children under four are adequately immunized, leaving thousands vulnerable to the serious threat of infectious diseases which could have life-long consequences."

Dr. Robert H. Sweeney on Child Health:

- ."The data supports our worse fears--the Surgeon General's 1990 Health Objectives for Children now appear to be virtually unobtainable, a stark reminder of the unsatisfactory health status of too many of the nation's children."
- ."Rates for infant mortality, teen pregnancy, low birth rate, death by accidental injury, HIV infection and teen suicide are all indicators of this failure. Between 1982 and 1986, the rates each of these indicators for the United States as a whole and for many individual states, have shown little improvement. In some states they have worsened."
- ."Poor children must overcome a number of financial barriers to receiving appropriate medical care in a timely fashion. Approximately twelve million children do not qualify for either public health programs or private health insurance. Health care services and providers are poorly distributed in rural and inner city areas. Education programs on disease prevention and health promotion are inadequate to meet the need."

The commentary of these four health professionals clearly underscores the need for health care access for children and families becoming a top national priority. The direction that the sub-committee is taking on this serious problem is commendable. The pending legislation, Medicaid Child Health Act of 1991 (S2459) along with the proposed increase in funding for the Maternal and Child Health Services Block Grant is a sound beginning towards health care equity for children of the United States.

Respectfully submitted,

Charles C. Williams
Charles C. Williams, Director

CCW:mw

United States Senate

WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name:

Patricia Flanagan

Address:

114 Clifford St

Lansing MI 48912

Representing:

Mother on ADC & Council Against Domestic Assault

I invite you to attach a prepared statement or to submit your written

testimony:

As a single mother on ADC & going to school I have great difficulty in finding any form of medical help for my four children. I have one daughter who is physically & mentally handicapped and services for her are extremely difficult to get.

Even on medicaid having a tooth pulled instead of fixed is not my choice of ^{health} maintenance.

Without insurance or w/medicaid the discrimination in services is so vast in regards to people w/money or insurance.

Help is needed as it is not always a case of being poor that creates the differences in medical care.

My name is Rita Flanagan. I am the Special Needs Coordinator for the Capital Area Community Services, Inc. - Head Start preschool program.

Capital Area Community Services, Inc. - Head Start provides pre-school services to 873 children in the 4 county area (Ingham, Eaton, Clinton, and Shiawassee). Most of the children have Medicaid Insurance, a small percentage have private insurance coverage. However, approximately 5% of the children have no health insurance coverage at all.

CASE HISTORY #1:

A family of four, both parents are employed full time at minimum wage jobs. Neither employer provides health insurance benefits. The family does not qualify for any kind of assistance due to their income.

This family moved to Michigan from Arizona 9 months ago. Their physician in Arizona recommended the 4-year old son have surgery to place tubes in his ear. The boy has a long history of chronic ear infections, almost monthly prior to the surgery recommendation. Since moving to Michigan, the parents have been unable to afford the kind of care they feel their child needs. They have noticed a gradual loss of hearing, evidenced by the child not being able to hear them when they talk to him; he needs to look directly at their face in order for him to understand what they are saying. He also turns the television sound up higher than necessary for the other family members to hear it. The final concern they have is that they have noticed a slow deterioration of his speech skills, and no progress in mastering sounds that he should have mastered by his age.

The parents cannot afford to take their child to a local doctor on a regular basis for the care he needs for the chronic ear infections, much less pay for a specialist to do the tube-insertion surgery they feel their child needs. Not only does this child need an examination by an ENT, he also needs a complete audiological examination to determine the extent of hearing loss (hopefully it is not too late for treatment to clear up any hearing loss before it becomes permanent). He may also need a Speech and Language evaluation and speech therapy to correct speech problems that have developed and bring the child's abilities up to an age appropriate level.

CASE HISTORY #2:

A family of six, father unemployed, mother employed full-time at a minimum wage job. One set of twins in the family, one of the twins has cerebral palsy with left side weakness. Multiple family problems, including separation of parents, no health benefits. The children's Medicaid has been discontinued because of the mother's employment.

Some weeks ago, this child (the twin with CP) had some type of seizure in the Head Start classroom. The teacher urged the mother to take the child to a physician for a complete physical evaluation. The parent has no Medicaid, no insurance, and no money. The child's regular physician has moved from the area and the parent has to find a new physician. The mother is not able to find a physician who will see her child without requiring payment at the time of service. Since the child is enrolled in the program, Head Start was able to pay the doctor bill so the child could be seen immediately. If Head Start had not paid, the child would have had to wait until the parent could pay cash for the visit; this may have taken months for the parent to save enough money to cover the cost of an office visit.

At the present time, the mother has resigned her job and the family is re-enrolled in Medicaid.

CASE HISTORY #3:

A single parent with three children. The mother works part-time at a job that pays minimum wage. At this time, the parent has no insurance or Medicaid. The children have been on and off Medicaid depending upon the ex-husband's working situation and insurance benefits.

The child is four years old, weighs only 25 lbs. and is 36 inches tall. A doctor from the Health Department wants the child to have a complete examination by a Pediatric Specialist because of the growth concerns. This child also has a history of ear infections (4-5 times per year) and the parents have concerns about his hearing and speech development as well. This mother has no funds to obtain the evaluation needed by a specialist; it often requires a wait of 6 months for an appointment with the specialist and there is no guarantee that the child will be covered by his father's medical insurance or Medicaid at the time of a scheduled appointment so far in the future.



May 29, 1990

The Honorable Donald Reigle
 United States Senate
 1207 Dirksen Senate Office Building
 Washington, DC 20515

Honorable Senator Riegle,

Thank you for inviting me to take part at the hearing to discuss issues surrounding provisions of health care to all children in the state of Michigan. Our health care system is fragmented, in that all levels of society do not have access to it. The children of today are tomorrow's Michigan and National leaders. Good health is critical to the development of individuals who are competent, function dependably and effectively on the job and are able to serve as a responsible and contributing member of society.

The health status of a child begins in the womb. Flint Osteopathic Hospital has been a provider of the Maternal Support Services program since funding became available in October, 1987. Our program has cared for over 1400 patients in that program to date. The goal is to have a more positive outcome at birth for the infant. The program offers support of a non medical nature for nutrition, psychosocial and nursing follow up. We transport patients to Doctor's offices for appointments and collaborate with the physician for a plan of care for the patient throughout the pregnancy.

The program is working! Statistics for 1988, our first full year as a provider, indicate an average gestational period of 36.3 weeks, average birth weight of 6 pounds, and an average APGAR score of seven (7) at one (1) minute and eight (8) at five (5) minutes. Thus far for 1990 average statistics indicate an average gestational period of 39.6 weeks, average birth weight of 7.1 pounds, and an average APGAR score of eight (8) at one (1) minute and nine (9) at five (5) minutes. The program has been effective! We have made a difference in that the outcome is more positive for infants whose mothers participated in the Maternal Support Services program.

I wholeheartedly support the expansion and improvement of Medicaid benefits for improved delivery of care of all children. Without it our future generation is at risk and very vulnerable.

Thank you for the opportunity to share my thoughts and available information with you.

Respectfully,

Phyllis Campbell

Phyllis Campbell, RN
 Director of Nursing
 Flint Osteopathic Hospital

bjo

GENESEE COUNTY MEDICAL SOCIETY
 806 Tuuri Place
 Flint, Michigan 48503
 Telephone 238-3781



TESTIMONY

TO THE U. S. SENATE FINANCE SUBCOMMITTEE
 ON HEALTH FOR FAMILIES AND THE UNINSURED,
 WEDNESDAY, MAY 30, 1990

The Genesee County Medical Society would like to thank Senator Riegler, Jr. for inviting our written testimony on Access to Health Care for Children.

The Genesee County Medical Society has been a proud and integral participant in efforts to improve access to health care for the uninsured and under insured children of Genesee County. Its most recent direct initiative relating to this type of activity has been through the Health Care Access Project and the Physicians Sponsor Plan sponsored by a grant from the Robert Wood Johnson Foundation, the Mott Foundation, the Michigan Department of Social Services, and the Genesee County Department of Social Services.

The Health Care Access Project and the Physicians Sponsor Plan essentially function as a simplified managed health care system for G.A. and Medicaid recipients in Genesee County. Physicians have heartily participated, due to the fact that much of the paperwork has been eliminated as duplication of services. This has resulted in a dramatic increase in access of care for the persons covered by General Assistance and Medicaid in this County. That dramatic increase in access has also resulted in increased physicians satisfaction.

We would heartily recommend the incorporation of an HCAP/PSP type of program for the maternal and child component of the health care system. If we can be involved in this process in any way, we would dedicate ourselves to an active role.

Senator Riegler, Jr. is to be commended for the activist position that he has taken related to health care for families and perinatal issues.

Submitted by:

John W. Tauscher, MD
 John W. Tauscher, M. D.,

President, Genesee County Medical Society

Cathy O. Blight, MD

Cathy O. Blight, M. D.,

District Director of the Genesee County Medical Society
 to the Michigan State Medical Society

Peter A. Levine
 Peter A. Levine, M.P.H.,
 Executive Director, Genesee County Medical Society

JWT/COB/PAL/wjf - 5/29/90

My name is Evelyn Gladney. I am employed by Capital Area Community Services as a Health Coordinator/Nurse. I am a registered nurse.

In September 1989, this child went to the dentist to have a dental screening which is required by Head Start. The child had medicaid at that time. The dentist referred the child to the pedodontist for three extractions and nine restorations.

When the child went to the pedodontist in December 1989, he reported that work was needed on 17 teeth and the total cost was \$1,073.00. Head Start was only able to pay \$300.00, when the pedodontist was informed of this he stated he might as well do nothing since \$300.00 would not even begin to pay. This is what he did. NOTHING!! The child still had medicaid but the pedodontist would not accept medicaid and no other medicaid accepting dentist would do the work due to the extensiveness.

In January 1990 the child's dental problems became worse. It was reported that she could no longer eat and could only drink warm fluids. If she went outside the cold air made her teeth hurt. The child was often in pain and agony.

On January 31st, the Family Service Worker called another dentist and told him of the child's situation and requested that he consider fixing some of the child's teeth to alleviate the pain. He too refused, saying she needed a specialist and he would start on her teeth and interfere with what the specialist needed to do.

In February 1990 the child finally saw a dentist who extracted four teeth. Her next appointment is late May to the pedodontist again who will do another exam and inform us of the cost.

Presentation of Jeanne Paluzzi
 President JGP Marketing Group International, Inc.
 Member, (Mich) Governor's Task Force on Access to Health Care
 MICHIGAN PUBLIC HEALTH ASSOCIATION
 May 21, 1990
 Southfield, Michigan

I'm last on the list again. . .just like the presentation to the Greater Detroit Area Health Council in January. Being in last place is not always good

-- in a horse race, in academic standings, in your baseball league, in a political campaign.

But it's good to be last in a presentation, in an argument. It's the best place to be. We get to respond to the remarks of others, tie up loose ends, etc.

In a few minutes this session will close -- and while I have the last word here, in a sense, the debate will go on in corridors of hospitals, in the classrooms of academia, in courtrooms; in legislative chambers, board rooms and bedrooms -- and the media.

You, our audience today, are in the public health arena. I have a rather whimsical question: how do you fit with the private health industry? Very carefully, I imagine.

Back to the Task Force.

The debates in the Task Force went on for two years. I was the small business representative, addressing the concerns of those who meet a payroll, who put their home equity, retirement and other personal assets at risk -- and who have social, political philosophies at both ends of the conservative-liberal spectrum. I also co-chaired the Problem Identification Sub-committee.

At first, the thrust of the 40 people on the Task Force just seemed to be to get those unfortunate people who have jobs but no insurance into an insurance plan -- and magically the problems of access would be solved. And I felt the score in this game was 39 to 1.

The people and the processes of these two years were interesting to observe, fascinating to be part of, challenging enough to be vocal about, -- sometimes very vocal -- and rather exhausting at times to keep on top of, as a volunteer who had some other priorities. But I wouldn't have missed this for anything.

We shared ideas, concepts, pre-conceptions, numbers, projections and politics. And we learned from each other. No one element then was the bad guy, even small businesses who didn't have insurance. -- By the way, in case you're wondering, I have carried health and life insurance since the day I opened in early 1979.--

We asked each other, the Academic Consortium -- and an ethicist a lot of questions. Some of which have no answers -- yet.

Here, briefly, are eight which I share with you, and which did finally have answers of some sort.

Then I have three questions for you to consider.

First the eight:

1. If every employee has insurance, will that take care of the uninsured and under-insured population? No -- less than one-half. What about the rest?

2. If every employer must carry insurance, will they have the same costs, i.e., pay the same rates for the same coverage? No -- it depends on industry risks, age, size of the company. Actuaries are having a field day. And small business pays approximately 35% more than big business for approximately the same coverage.

3. A two-parter: If they carry insurance, will every employer get the same tax deduction? No, not if you are a sole proprietor -- which most small businesses are. Will the small businesses who have had health insurance all along get the same subsidy being offered to those who haven't carried insurance -- for whatever reason? Probably not.

4. If people work two jobs, both with more than 15 or x number of hours per week, which employer pays or do both of them? We don't know yet. Please keep in mind that the more you add to the cost of a job, the fewer jobs you are going to have around, or create.

5. If everyone is insured, will that lower the cost of health care? Not when providers charge more if you're insured than if you pay cash.

And not when providers still have to have several employees simply to learn and process multiple types of forms for reimbursement.

To switch from the practical to the more conceptual:

6. If everyone is insured, will this assure that everyone who needs it or wants it will get what they need or want? No. Only if everyone has

the same policy -- and what is available today to people on some sort of public assistance beats a lot of coverage offered with insurance policies in the private sector. Then, too, some people don't want to go to doctors and hospitals. Others who do, don't know where to get it. And others don't want to be told when and where to get it. Choice is still a operative word in this country, in most instances.

Speaking of choice - we need to discuss and set public policy, about when life begins and when life ends -- and when and how to use extraordinary measures to start and maintain life at any age.

7. If everyone is insured, will this take care of the problem of health care costs? No. It's intertwined with malpractice insurance costs, a society that sues for everything, huge awards based on emotion rather than logic. It's intermingled with who is trained to do what most efficiently. (And we had input from nurses.) It's a reaction to technological advances and who gets to use how many machines in what territories. It's a result of using a hospital's emergency room as a clinic or a doctor's office.

8. If everyone is insured, will this take care of our health problems? I don't think that insuring everyone will add to the direct care of the large number of teen age mothers, drug abusers, AIDS victims, including hemophiliacs and many thousands of others looking for help.

Now, questions for you:

9. What is the difference between insuring everyone and national health program?

10. Is the government always the solution? Government is part of the problem and of the solution.

11. Who pays the new taxes -- what amount and what percentage?

Remember that insurance is only one mechanism for payment -- which is only one aspect of access to health care. And remember that insurance historically was designed to take care of unusual or costly or non-basic care.

Finally, there is a lesson to be learned from a parallel situation. People have come to us sometimes for a rescue operation, for whatever reason, and think that publicity right now can save them. But, a basic rule of our business is this: if lack of a good promotion or publicity

is the problem, then good promotion, communications, publicity will solve it. If the problem is due to any other reason, such as the nature of the product, price, or other factors, good publicity or other promotions will only exacerbate it.

That parallel, plus a knowledge of basic economics, business experience and political maneuvers, should tell us that throwing more money via insurance -- or taxes in lieu of -- throwing money into a bad situation that is due to more than a lack of money, is only going to make the situation worse. We've got to fix the situation first.

A government bail-out of the savings and loan industry, of the health care industry or any other industry where there are systemic problems will only lead to more chaos.

Let's take the next step together: educate and motivate all our audiences -- employees, constituencies, customers, patients and providers. We can be proud that we have the most advanced health care system in the world, spend the most in the world. But we can't be proud that we have some of the worst health statistics in the world.

We can send men to the moon and telescopes to outer space . . . and that takes more than technology. It took dedication and a national will.

Let's now send our people, our citizens, our institutions a message . . . regardless of where you work, have worked, will work, or can work, you can have access to health care -- if you together have the will to make it happen. So that none will be first - and none will be last in the system.

Thank you.

Note: No reproduction of any portion or all of this speech may be made without the expressed permission of and credit to the author.

MPHAHCTF

Health for Families + ^{the universal} Hearing - 5-30-90
 Senator Donald Biggle

Health care for children

- As a school nurse for a Young Parent Program for the past 20 years I have seen numerous child go without medical service because parent had no insurance, but even with medicaid services are hard to come by. This last summer in Kalamazoo one of the Peds Clinic which served over 3,500 medicaid clients decided to move from its hospital connection into a private practice. They dumped most of their medicaid clients onto the community.
- Telling them to get themselves another MD that they would no longer serve them, while there were no ^{very little} other services to be had - They also started to refuse to see patient on medicaid unless they had medicaid card in hand. Re certification of medicaid monthly should be changed to perhaps every 6 months or each year. Clients have to go down to DSS monthly with proof of income + wait six hours to see worker. If the card doesn't come through the mail on time, I've seen young babies with bed ear infections have to wait a week (in pain) or be taken to ER because the Dr wouldn't see the child. Even though I knew + they knew she was recent ^{teen mother} but her card hadn't come through the mail - (Debra ~~was~~ - Apnea child - hospitalized)
- Placed on monitor - 80% vs 200/300 ER - change (tax paper) -

Wic funds - being cut - \bar{c} Infant mortality already High in this country How can we even consider cutting these funds Need to be Raise Children are our future yet this country treats them like 3rd class citizens, because they can't speak for themselves - nor can they vote.
 - we need to increase money's for children instead bailing out Saving & Loans -

As President of the Michigan Assoc concerned with School-age Parents - I've heard of ~~so~~ ~~so~~ many Teen Pregnancy Program in financial difficulty because they got start-up money from the federal government or state but have no means to continue serving these young Parents when this money dries up. We need continuation funds for these programs which have proved themselves to be working in Education the young Mother. Helping her be a better Parent & get her High School Diploma - and eventually get herself off the welfare Rolls - cut down on the number of child she has & become productive citizens —

Helen Lancaster QD
 MACSAP President
 1829 Turwill Lane
 Kalamazoo, Mich 49007

* Debbie, a teen mother - had applied for medicaid but hadn't received her card. Her newborn baby, was having respiratory problem. She returns to the school for teen parents. When her child was 3 weeks old and told me her baby had a "bad temper and held her breath until she turned blue". I told her this was not normal and the baby needed to be seen by a doctor. I made an appointment for Debbie's baby at the Peds Clinic. She took her baby to the doctor, that same day, but came back to my office in tears the clinic won't see her, because she didn't have her medicaid card in hand. As a nurse I called D. SS got the medicaid numbers, but the Dr's office still won't see her, just insisted needed her card in hand. ^(mother refused to go to ER - she didn't see the problem as life threatening) I told me to sent her to the Emergency room. As a tax payer this made me angry - Instead of \$30⁰⁰ office call, we taxpayer would be paying \$200 - 300 Emergency cost. I gave Debbie the \$30⁰⁰ and sent her back to the Dr's Office. On seeing the child, she was send right to the hospital, Placed on a Apnea monitor. If sent home with no medical attention this child could of been another stat - S.I.D - This is not an isolated case but happens often - Helen Lancaster RN

Many times ^{teen mothers} and ~~parents~~ at school children have ear infection + are told to go to ER because they don't have medicaid card in hand, to go to the MD's office

One of our young mothers³ walked over 10 blocks to her prenatal care this winter, because of no transportation, with her toddler. It was a very bad cold day and she arrived at the clinic only to be turned away because she arrived too late. Many teen pregnancy programs try to provide transportation to their clients, but due to funding have to cut back on this needed part of their programs. Then we wonder why these patients are no shows or don't seek out prenatal care early. Prenatal clinics are located miles away from where they live and we demand the patient come to us, instead of ~~we~~ taking the clinics to them —



Michigan Academy of Physician Assistants

1305 Abbott Road, Suite 102, East Lansing, MI 48823 / Phone (517) 337-9797

Constituent of the American Academy of Physician Assistants

Senator Donald W. Riegle Jr.
 Chairman, Finance Subcommittee
 Health for Families and the Uninsured

May 18, 1990

Senator Riegle,

Thank you for the invitation to attend the May 30th hearing on access to health care for children. Unfortunately, I have a prior commitment which precludes my attendance, however, I would like to offer this written testimony in support of your efforts (Medicaid Act of 1991;S.2459) to expand eligibility, improve benefits and improve the delivery of healthcare to children.

Physician Assistants as providers have first hand experience with the many issues of access, quality and cost containment, and as taxpayers, are very sensitive to the need of balancing multiple objectives to obtain acceptable goals. Like myself many other Physician Assistants provide health services in geographic areas which are socially and economically depressed. The uninsured, working poor, population is rapidly expanding. Parents of uninsured children hesitate or delay seeking medical intervention for their children because of the lack of financial resources. The problems are endless, and an emotional response alone is not sufficient to correct the disproportionate disadvantage of uninsured children. Barriers to healthcare have a lasting influence on the lives of these children and extends into every aspect of their development.

Physician Assistants have demonstrated a willingness to provide health services in underserved areas. They provide quality health services under the direction/supervision of licensed physicians and greatly improve the access to care for thousands of children throughout this state. However, the lack of adequate health insurance and limited financial resources erect barriers to access which are beyond the control of the

90 MAY 24 PM 1:58
 LANSING OFFICE

providers. The marketplace does not treat kindly those without the ability to pay for needed services. The standard of care for poor, uninsured children, is much different than children with adequate health insurance.

Below are suggested solutions which may increase the access to health care for uninsured children.

- 1) A national health care policy which reflects the belief that all children deserve access to appropriate primary care health services which include the diagnosis and treatment of common illnesses/injury, preventive health care, emergency services and health education.
- 2) Lower Medicaid eligibility threshold requirements or allow buy-ins to provide coverage for uninsured children.
- 3) Increase availability of healthcare providers in socially and economically depressed areas which are underserved.
 - a) Financial incentives i.e. relief of medical education debt, or tax relief for income earned providing services.
 - b) structuring medical education programs such that students may be sensitized and exposed to the needs of the poor.
 - c) recruit students from underserved areas with incentives to return upon graduation.(scholarships, loan forgiveness, etc)
4. Flexibility in state laws/regulations which will allow appropriate utilization of Physician Assistants in providing medical services to uninsured children.
- 5) Reimbursement policies which are flexible and do not prohibit the use of Physician Assistants in the provision of medical services.
- 6) Implementation of Resource Base Relative Value Scale for Medicaid programs which includes services provided by Physician Assistants.

I apologize for not being able to attend this meeting, but I assure you of my personal commitment to the healthcare needs of uninsured children.

Sincerely,

John R. Kearney
John R. Kearney PA

President-Elect

Michigan Academy of Physician Assistants



6215 West St. Joseph Highway
Lansing, Michigan 48917
(517) 323-3443
Spencer C. Johnson
President

TESTIMONY FOR THE SENATE FINANCE
SUBCOMMITTEE ON HEALTH
MAY 30, 1990

The Michigan Hospital Association appreciates the leadership of the Senate Finance Subcommittee on Health on the issue of the uninsured. The issue of guaranteed access to health care is one whose time has come. The uncompensated care load which hospitals are carrying is becoming too burdensome for Michigan hospitals to sustain. This figure has grown from \$92.2 million in 1980 to \$352 million in 1988. However, this issue should not be discussed in terms of balance sheets or budgets. The fundamental right of access to health care is consistent with the principles this country was founded upon. This principle should guide us and provide the necessary initiative.

The Michigan Hospital Association has embarked upon a project called Vision 2000. This project calls for the 1990's to be a decade of vision to create a health care system by the year 2000 that meets the needs of government, consumers, purchasers and the system itself. Health care has seen radical change in recent years and all projections are that this dynamic will continue.

There are three basic objectives to the Vision Project.

Guaranteed access to basic health care benefits for all citizens.

There should be no financial barrier to essential health care. The only way to achieve this objective is through universal sponsorship: Everyone has to belong to some private or public program that covers a substantial portion of basic health care costs. This does not entail that everyone have the same health benefits but rather that everyone have at least a basic entitlement. It does not entail that there be a single financing mechanism but rather that the multitude of financing sources and mechanisms add up to universal coverage.

There will always be cracks and people that fall through them, therefore, there will always be the need for charity. Charity, however, should be used to cover cracks rather than to attempt to patch large holes in our social fabric.

Payment systems that encourage and reward effectiveness while providing fair and adequate compensation to providers. Effective performance on the part of providers involves the efficient production of health care services and the efficient weaving together of those services toward the production of health and alleviation of disease. It involves avoiding unnecessary and ineffective treatments as well as selecting the least costly and most effective location for service.

Payment systems that achieve this objective will tend toward integrated payments. Integrated payments will combine or coordinate payment to health professionals with payment to health organizations while at the same time moving away from payment for specific services toward payment for a total benefit. This will ease the movement of the patient between different organizations and settings in search of the most appropriate and cost effective treatment.

A payment system which does not provide fair and adequate compensation to providers is not viable in the long-term unless it is sustained by cross-subsidies or hidden transfers from one payment system to another. Different prices to different purchasers are only justified when based upon cost savings from administrative efficiencies or the economies of scale.

Control that is decentralized and invested in the community to the greatest extent possible. Health care will always be more than a product bought and sold in a marketplace. It is a vital community service intensely local in its particulars. While some decisions are appropriately made in the marketplace and others in the political arena, not-for-profit organizations should continue to dominate our health delivery system. The not-for-profit nature of hospitals has kept health care decision making local and community focused. Through this means of organization the community is empowered, participates in its health care arrangements, and is able to fully recognize and accommodate the factors that make each community unique.

As the not-for-profit organization should remain at the heart of the health delivery system, so too should the primacy of the doctor-patient relationship remain at the heart of health delivery. Every patient needs a sponsor who is responsible for guiding and informing his or her choices and decisions about health care. Subject to the requirements of the other objectives, this relationship should be maintained and preserved.

An essential part of the equation to ensure equal access is to have in place a health care system which can meet the needs of the public as efficiently as possible. Our Vision Project incorporates a health care system that evolves to meet the changing needs of the population.

The cost containment issues in the proposal submitted by Senator Riegler do not advocate paying less for the care delivered. This is a positive and fresh step. Cost containment by looking at the demand side of the equation is appropriate. Providers should be efficient but too often cuts in reimbursement under the guise of cost containment are nothing more than payment avoidance. This listing of medical liability insurance in the proposal is also viewed as positive by MHA. Michigan has the highest medical liability premiums in the nation. The State average is \$5,600 per year per bed, the national average is \$1,600. This excess could be better spent on patient care.

Ensuring universal access will be a difficult task. Leaders will be faced with tough choices. Leaders of Michigan's hospitals stand ready to make those choices as providers of health care and to assist other sectors to get the job done.

United States Senate

WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Mrs. Pat MathewsAddress: 6309 Marsh
Haslett, MI 48840

Representing: _____

I invite you to attach a prepared statement or to submit your written

testimony: Her husband died a few
years ago. She had to get two
part-time jobs to survive.At the one job she actually
worked full-time hours - but
received no benefits. As
trying to go to school, but
having a hard time coming
up with money. Wants to
better ~~the~~ herself, but companies
take advantage of people by
making them work full-time,
calling part-time & offering
no benefits.



Michigan Head Start Interagency Specialist

101 E. Willow Street
Lansing, Michigan 48906
517/ 482-1504

May 31, 1990

The Honorable Donald Riegler
105 Dirksen, Senate Office Building
Washington, D.C. 20510

Dear Senator Riegler,

On behalf of the Michigan Head Start Programs, I would like to thank you for convening the hearing to address the Subcommittee on Health for Families and the Uninsured. I attended the hearing with a number of representatives from local Head Start programs including parents and health and disabilities coordinators. Many of the viewpoints expressed by the expert witnesses are shared by Head Start associates who submitted written testimony. At your request for input, I would like to reiterate a few concerns of Michigan Head Start programs.

Head Start Performance Standards require that all enrolled children, ages 3 to 5 years, shall have a complete medical and dental screening and examination. A treatment and follow-up plan will be developed for a child when appropriate. The majority of our families on public assistance are eligible for Medicaid. For these families the greatest problem is access to health care. Many providers hesitate or refuse to take Medicaid patients for the reasons stated at the hearing, low-reimbursements and blocking time that could be used to examine paying patients.

For low-income families not eligible for Medicaid, Head Start must access other community resources to pay for a child's treatment. Some options include State and Local Health Care programs, volunteer agencies or providers, and organizations such as the Lions Clubs, Religious Associations, or Community Clubs. The resources of these providers are in great demand and funds may not be available to serve all needy children.

Transportation, child care for other children, getting time off from work for those parents who are employed are also problems which make it difficult for families to access care. Head Start is obligated to assist these families with transportation and locating participating physicians or other providers.

Head Start funds can be used as a last resort to pay for medical treatment or supplement existing services. Head Start health and disabilities coordinators scramble to find adequate, appropriate, and timely medical services for our children.

One health issue that is often brought to my attention is the lack of dentists available to serve Head Start children in Michigan. Reimbursements are again a problem, but dental care is not always

considered a medical condition. Treatment of dental problems is just as crucial as other medical problems. A child with a severe toothache will probably have difficulty learning or paying attention. I was told about a child who has a full set of dentures at age five. Obviously, this child is faced with severe dental problems, but self-esteem issues must also be addressed for this child who is at-risk of being considered "different" by his peers.

For children with severe health problems, Head Start not only addresses the medical and dental needs of children, but also the mental health needs of the family to cope with the problems. Community Mental Health waiting lists are extremely long. Funding for services to children is in jeopardy at the state level. Caseworkers are overloaded with crises; therefore little time is left over to help families cope with medical problems. It is imperative that mental health be considered part of any child's health care treatment plan and be covered by insurance programs.

Head Start is seeing more and more children whose health, development, and educational achievement are being compromised because of drugs, child abuse, hunger, and poor nutrition. The Head Start philosophy speaks of caring for the whole child through a process of comprehensive services and building stronger families. Health care is an essential component of this process.

We appreciate your efforts to promote quality health care for our children, and support your initiatives to address the problems of access to health care and uninsured families.

Sincerely,



Michele M. Payne
Interagency Specialist

cc/ Michigan Head Start Association

United States Senate

WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name:

Thomas P. Miller
Thomas P. Miller - A Glenbeigh of K.C.H.

Address:

750 Fuller Ave N.E.
Grand Rapids Mi 49303

Representing:

Glenbeigh of Kent Comm. Hosp. Adol. C.D.

I invite you to attach a prepared statement or to submit your written testimony:

Pertaining to access to Drug & Alcohol Abuse Health Care, It is more a matter of mandated treatment rather than types of insurance. There are programs for all types of insured and non-insured adolescents however without court and parental pressure these individuals go untreated until delinquency occurs.

Obstacles: Laws pertaining to confidentiality
Adolescents right to refuse treatment

United States Senate

WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Joseph Ann Murphy

Address: 190 C. Wash Ave.
Battle Creek, Mi 49068

Representing: Calhoun Co WDC program

I invite you to attach a prepared statement or to submit your written

testimony: In Calhoun County, particularly Battle
Creek, it is very difficult for children of
lower economic status to obtain adequate
medical care. If they are on medicaid, the
pediatricians will not accept them. Parents
who work minimum wage cannot afford
insurance, it doesn't come with their employment,
and they sometimes can't qualify for medicaid.
Those children receive NO medical care

My name is Dora Ostrander, I am separated and raising 4 children by myself. I have to have a job that provides current medical care for my children. As a result of my families past medical bills I will be paying a portion of my income to Lansing General and Doctor Neff for at least the next 10 years.

My third child, Walter, is now 7 years old and he is covered under Crippled Children Insurance and also my Health Central Policy but from 1985-86 my son was not covered under any medical insurance. He was diagnosed as "severe asthmatic" in 1984. As a result of his "pre-existing condition" my husband's medical insurance would not cover Walter.

In late 1985 while my husband was layed off from his job as a cement finisher we applied for medicaid, DSS said we made too much money for medicaid based on our family size of five. My husband's insurance covered everyone in the family except Walter. This insurance was \$1,000 deductible per person or \$2,500 for a family. This insurance did not cover even when my 2 other children had to see the doctor.

In the 12 month period from September 1985 until September 1986 my son was hospitalized 18 times with asthma or related problems. There were also at least twice that many visits to the emergency room and numerous visits to the doctor. Walter's medications alone during this period were costing us between \$200 and \$400 a month. We also had to pay the rental of a nebulizer to help him breathe and the cost of the tubing and mouth pieces for the nebulizer.

In early 1986 the doctor suggested that I contact Crippled Children's Services regarding insurance for Walter. They said asthma was not a covered condition. I fought them and got documentation regarding the seriousness of his asthma and finally got him covered in late Spring of 1986. They would not cover any of the medical bills from before the date I applied for services. They also would not cover the bills from Lansing General Hospital because it was not a participating Crippled Children's hospital. They also would not cover anything for Walter unless it was asthma related.

As a result of the asthma medications Walter had to take on a daily basis he became extremely hyper-active and had a short attention span. He had many accidents during this time that were not covered under Crippled Children. He had stitches 3 times, 2 concussions and 2 accidental poisonings. We had to pay for all of these emergency situations because they were not considered asthma related.

During this period of time it took almost every bit of money we had just to pay Walter's medical bills. Not only did I have an ill child to take care of and worry about, I also had to spend my time and energy trying to make ends meet and contacting agencies trying to get them to cover some of his medical expenses. The only agency that helped us was Easter Seals, they paid for a visiting nurse to come to the house and train me on how to give Walter his aerosol treatments and other treatments and on how to keep the house asthma proof, which meant constant cleaning, dusting and keeping him out of things he was allergic to.

As a result of Walter's medical bills we were eventually evicted from our home that we had lived in for 2 years, our rent was 5 month's overdue.

I feel that if the Medicaid Child Health Act would have been in effect, the early years of Walter's life would not have been as traumatic for myself or for him. I also feel that a portion of this bill to cover dentists and eyeglasses would be a great help to many families.

My job provides great medical insurance but does not provide for dental or eyeglasses. My children are not able to go to the dentist for check-ups and cleaning because I cannot afford it. My oldest two children (8 & 10) have not been to a dentist for 2 1/2 years. When my daughter needed eyeglasses because of failing a vision test at school I had to contact the Lion's Club to provide her with glasses.



May 23, 1990

Senator Donald Riegle
 Chair, Senate Finance Subcommittee on
 Health for Families and the Uninsured
 Central Regional Office
 Suite 705
 109 West Michigan
 Lansing, MI 48933

Dear Senator Riegle,

We are very concerned about the lack of adequate and affordable health care for our children in Michigan.

As members of the Health Care Specialty Work Group of the East Side Initiative, (see enclosed newsletter) and, therefore, persons living and/or working on Detroit's east side, we are aware that most east side families are living under conditions of extreme poverty. We are enclosing a fact sheet (see enclosed) which we compiled to describe many aspects of public health and social concern.

We urge you to continue to work toward decreasing the complexity of problems related to lack of adequate and affordable health care for our children and for their families as well. Please include this letter and its enclosures as part of the written testimony to be developed as the official transcript of the May 30, 1990 hearing, "Health Care For Children: Protecting America's Future".

Sincerely,

Sally Smolen, RSM

Sally Smolen, RSM
 Associate Director

on behalf of the ESI Health Care Specialty Work Group

Enclosures: PSRI newsletter
 ESI fact sheet
 Health care group membership list

PSRI

Poverty and Social Reform Institute

28600 Eleven Mile Road
 Farmington Hills, MI 48018
 313/473-1880



Poverty and **S**ocial Reform Institute
Newsletter

Winter 1990

Volume 1, Number 1

A Word From the Director:

Collaboration is Key to First Year

When the PSRI staff chose *PS* as the name of this newsletter, we did not mean it to be an "afterthought" or "addendum." Rather, we envisioned our publication as a "rearview" glance—a look at what we've achieved with a view toward what we intend.

All of the stories in this issue are, essentially, one story: that of the Institute's first year. During this period our progress, like our projects, has been "holistic." Thus our first planning activity, the Think Tank, combined with our first project, the Community Assessment of Human Needs, to produce our first program, the East Side Initiative.

The Poverty and Social Reform Institute is rooted in two concerns: First, the increasing urgency of the problem of poverty; and second, the fragmentation of responses to that problem. The needs of the poor vie for attention—as if education were more important than food, or health care more urgent than shelter.

PSRI believes that the interrelatedness of the problems of poverty mandates comprehensive, holistic approaches. Such approaches achieve success through collaboration—with the poor themselves and with those who work on their behalf.

Our Institute is itself a testimony to collaboration. Although we are nonsectarian, we've received key support from four religious organizations—the Religious Sisters of Mercy, Detroit; the Servants of the Immaculate Heart of Mary, Monroe; the Dominican Sisters, Adrian; and the Sisters of St. Joseph, Nazareth.

We've been assisted, too, by Mercy Health Services, which has provided space and resources for PSRI, and by a superb Board of Directors, which has graciously given time and talent to insure the Institute's firm foundation.

I am personally indebted to a staff of professionals with whom I collaborate each day—Carol Quigley, IHM, and Sally Smolen, RSM, PSRI's associate directors; Marie Thielen, RSM, our development coordinator; Therese Villeroi, RSM, administrative assistant; Rosemary Charron, RSM, education specialist; Donna McKenzie; Sarah Hackett; and volunteers Rita Brocke, RSM; Sharon Jourdan; Nancy Ann Russo; and Marilyn Zobel.

This newsletter documents their efforts and reaches out to those of you who have expressed interest in dealing with poverty in a comprehensive, holistic way. We are a new organization and there is much to be done. Your skills, services, support—or simply, interest—are warmly welcome.



Photos at right

Does anyone doubt the importance of a well-rounded, healthy childhood...

Crime, Drugs are Urgent Concerns

Crime, personal safety, and drug abuse are the foremost concerns of Detroit's poor, according to the Community Assessment of Human Needs (CAHN), a 10-month study done by the Poverty and Social Reform Institute in the poorest areas of the city's east side.

A key project in PSRI's first year, CAHN was commissioned by Mercy Hospitals and Health Services of Detroit. The study was coordinated by Sally Smolen, RSM, associate director of PSRI, with assistance from Marie Thielen, RSM, development director for PSRI and former administrator of Detroit's Samaritan Hospital.

Survey interviews took place between November 1988 and April 1989. In all, CAHN staff spoke with 244 area residents, 115 human service providers, and 26 community leaders. Responses from one-on-one interviews held with the last two groups provided a framework for personal interviews and group discussions with the residents themselves.

Although concern about drug abuse pervaded all responses, the study revealed differences in the way the three groups prioritized the needs of the poverty-ridden area. Whereas service providers and community leaders emphasized health care and education, residents cited crime and personal safety as their most critical concerns. Marie Thielen explained, "Health needs are there, but people are overwhelmed by these other problems."

Both women were struck by feelings of powerlessness evidenced by those living in poverty. Smolen noted, "People with money can move away or protect their possessions; the poor lack that kind of control." Conversely, they were impressed by the spiritual resources found among many that they interviewed, which Thielen described as "a deep faith, simply expressed."

Results of the survey are expected to provide a knowledge base, both for Mercy Hospitals and Health Services and for PSRI, for meeting the needs of residents in the eastside community. In addition, the project established links within the community that will facilitate future action.



Think Tank Targets Poverty in Children

Does anyone doubt the importance of a well-rounded, healthy childhood, especially during the early formative years? Does anyone not see the enormous challenge this presents to parents who are poor, uneducated and unemployed?

In order to understand this challenge, PSRI convened three Think Tank sessions, composed of over 50 family and child-care workers, educators, substance abuse counselors, criminal justice experts, and others concerned with needs of poor children and their families.

These sessions were facilitated by Canice Johnson, RSM, a consultant with Community Creativity, Inc., a Washington, DC consulting group for organizational growth and change.

Processes of brainstorming, imaging, case studies, and small and large group dialogue led to consensus on the important elements of a preferred future encompassing the individual family and neighborhood. These elements were woven into a vision statement to be used as a framework for action.

The Think Tank advisory committee ultimately recommended that follow-up community sharing and planning be done in areas to be served prior to implementing new programs. It was agreed that the best approaches to meeting the needs of poor children were those that also empower the family and address renewal of crime-ridden, deteriorating neighborhoods. Such approaches are expected to become a part of PSRI's East Side Initiative.

PSRI Launches East Side Initiative

Initiative, says Webster, is "the power . . . to follow through on a plan or task." For PSRI, the East Side Initiative means following through on a task set by its own Think Tank and Community Assessment of Human Needs.

As the major project of PSRI's second year, the East Side Initiative (ESI) is an all-out effort to respond to needs of the poorest residents of Detroit's east side, as they were defined by last year's CAHN survey.

The Initiative is located in zipcodes 48213, 48214, and 48215, three of the highest poverty areas in Wayne County. Over 60% of the population lives below 150% of the poverty level. Fifty percent of its residents have not completed high school; 40% are female householders.

Carol Quigley, IHM, directs the project, with Sally Smolen, RSM, serving as associate director. Samaritan Health Services, located within the targeted area, has provided office space.

Phase I of the East Side Initiative involves formation of action planning committees composed of area residents, community leaders, and service providers. These groups will form around seven areas of need cited in the CAHN survey: substance abuse; crime and violence; education; housing and neighborhood deterioration; health; employment and economic development; and social support.

During several sessions from January until June, the groups will share data from the Think Tank and the CAHN survey; respond to presentations by resource persons; and review other successful renewal programs.

Following this, participants will propose action plans for use in the targeted area. Emphasis will be placed upon formation of community cooperatives, networking to promote collaboration among neighborhood groups, and leveraging of local community resources.

Throughout the East Side Initiative, special attention will be given to meeting the needs of 0-5 year-olds and their parents living in poverty. Two approaches--one with a health focus, the other with an educational focus--will be proposed during Phase I as models for implementation.

Poverty Quiz

1. How many Americans are poor?
2. How many Michigan citizens are poor?
3. Who makes up the poorest age group in America?
4. How many Michigan citizens receive--
 - (a) Aid to Families with Dependent Children (AFDC)?
 - (b) Food stamps?
 - (c) Medicaid?
5. What is the typical AFDC shelter allowance for a family of three in Wayne County?
6. What was the unemployment rate in 1988--
 - (a) Nationally?
 - (b) In Michigan?
7. Will minimum wage support a family of two above the poverty level?
8. How many children in Michigan are in foster care?



ANSWERS

1. 31.9 million, or 13.1% population (1988)
2. Estimated at 1.2 million, 13% population (1988) Last official number 1.3 million, 14.5% (1985)
3. Children; almost 20% are poor.
4. a. 445,500; b. 873,400; c. 916,200 (1988 monthly averages)
5. \$155 (1989)
6. a. 5.5%
b. 7.4%
7. No. Minimum wage is \$3.35, or approximately \$7000 per year. Poverty level for a family of two is approximately \$8,000 per year.
8. 15,200 (1988 monthly average)

Map

The East Side Initiative is in zipcodes 48213, 48214, and 48215-- bounded by Grand Boulevard on the west, Alter Road on the east, the Detroit River on the south, Flanders on the north.

Paper Probes Church Closings

The most controversial decision in the history of Detroit's Catholic Archdiocese was the subject of PSRI's first publication, "Catholic Church Closings: A Social Analysis."

Co-authored by Agnes Mansour, PSRI director, and Donna McKenzie, PSRI staff, the paper appeared in *Shattered Churches, Shattered People*, a recent tabloid published by Groundwork which discusses the church closings in terms of the "pastoral cycle" process of achieving social justice.

Representing an evaluative stage in the pastoral cycle, "Catholic Church Closings: A Social Analysis" presents both a historical overview of race relations within the Detroit archdiocese and a demographic analysis of church closings. It evaluates the closings in terms of papal encyclicals, the U.S. Bishops' pastoral letters on economic justice and racism, and in relation to recent pronouncements on the role of women in the church.

Copies of the publication can be obtained by writing the Poverty and Social Reform Institute, 28600 Eleven Mile Road, Farmington Hills, MI 48018. Or call 313-473-1880.



Every Problem an Opportunity

Community-based planning and collaborative action were major topics for discussion during a recent visit by representatives of three prominent Detroit community groups to PSRI offices.

The meeting was one of several PSRI staff is having with community leaders. Participants included Theresa Blaquiere, RSM, of Core City Neighborhoods, Ed Bobinchak of WARM, and Maggie DeSantis of the Warren-Connor Development Coalition.

Major points made during the discussion were:

- Long-range planning is worth the time and money spent.
- Individuals and businesses in the community need to be part of the planning process. "People can understand data," said DeSantis. "They just need help getting information."
- Collaboration between community organizations facilitates both delivery of services and procurement of funding.
- Development of leadership skills within the community is essential to empowerment.
- Community planning depends on creative problem-solving, not ideology.

Sounding a cautionary note, Blaquiere observed that in community planning "there are no small problems." "But," she added, "every problem is an opportunity."

The Poverty and Social Reform Institute is a private, not-for-profit organization. Executive Director: Agnes Mansour. Board of Directors: Armando Cavazos, President, Credit Union One; Dr. Arthur Johnson, Vice President for Communications, Wayne State University; Attracta Kelly, OP, Administrative Team; Agnes Mansour; Beverly McDonald, Executive Director, Michigan League for Human Services; Rt. Rev. H. Coleman McGehee, Episcopal Bishop, Diocese of Michigan; Margorie Polys, IHM, Administrative Team; Nancy Thompson, RSM, Administrative Team; Hon. Alberta Tinsley-Williams, Wayne County Commissioner; Dr. Charles Vincent, Assistant Dean of Admissions, Wayne State University Medical School; Hon. Joseph Young, Sr., State Representative, District 14.

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Farmington Hills, MI 48018

Poverty and **S**ocial Reform Institute
Newsletter

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EAST SIDE INITIATIVE
HEALTH CARE SPECIALTY WORK GROUP

FACT SHEET

INTRODUCTION

Poverty is characterized by high unemployment, lack of health insurance, reduced access to medical care, inadequate and unsafe housing, inadequate nutrition, higher mortality and morbidity rates, substandard sanitation -- all of which negatively impact health. Communities struggling with poverty and day-to-day survival are less likely to advocate for themselves.

DEMOGRAPHICS

The far east side of Detroit, specifically zip codes 48213, 48214, and 48215, are characterized by unacceptable rates of poverty.

The percentages of households in these areas which are below 150% of the poverty level range from 53.2% to 65.5%.¹

Households with incomes less than \$7,500 in these areas range from 32.5% to 42.2%.

These three zip codes comprise almost 135,000 people, of which approximately 67,000 are under the age of 18.

Households with children 18 years of age and under in these zip codes are: 48213 -- 48.5%; 48214 -- 34.4%; and 48215 -- 51.5%.

The Detroit unemployment rate is 11.1%, equalling 50,000 individuals.²

In these three zip codes, of the adults over 25, only 1/3 have completed high school.

Over 50% of the children in these three zip codes live in poverty.

HEALTH STATISTICS

In 1987, the Detroit infant mortality rate was 19.7 per 1000 live births, which was higher than ten other major U.S. cities, including New York City and Washington, D.C..³

In 1988, the Detroit infant mortality rate increased to 20.9 per 1000 live births.⁴

For these three zip codes, the range of infant mortality rates (1987) was even higher than for the city of Detroit as a whole--19.1 to 32.6 (highest in Detroit) per 1000 live births.⁵

Recent state analysis of childhood morbidity (1984 to 1986) showed that children living in poverty died at a rate 2.5 times higher than other children.⁶

CONCLUSIONS AND RECOMMENDATIONS

Infant mortality is a measure of a society's ability to care for its most vulnerable members. It is a very sensitive measure; high rates indicate conditions hostile to life.

Low birth weight is the leading cause of high infant mortality and morbidity.

Low birth weight babies have a high incidence of neurological impairment, which results in educational difficulties and limited employment options in adulthood.

The high rates of morbidity for children living in poverty predict a dim future for gainful adult employment, which not only reduces the inflow of tax dollars, but also increases demands on public funds.

It is prudent and necessary to increase existing levels of funding for public health and social services.

Lack of investment in the health of our children threatens the future of all of us, both short-term and long-term.

1. All statistics are taken from the U.S. Census (1980 and 1986 estimated data) utilized in the 1988-89 Community Assessment of Human Needs sponsored by Mercy Hospitals & Health Services of Detroit in these three eastside zip codes, unless stated otherwise.
2. Michigan Employment Security Commission.
3. Washington Post, October 16, 1989.
4. Michigan Department of Public Health.
5. Detroit Health Department.
6. Michigan Department of Public Health, Michigan Department of Social Services, Office of Children & Youth Services, Lifelines For Children: Child Mortality in Michigan, November, 1989.

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United States Senate

WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In
Name: Nancy Siefert, Children's Program Coordinator

Address: P.O. Box 14149
Lansing MI 48901

Representing: Council Against Domestic Assault

I invite you to attach a prepared statement or to submit your written

testimony: Children of parents who work part-time, of which a majority are women, or those whose employers don't offer health benefits often don't get proper health care because parents must pay out of pocket for health care, and often it simply isn't affordable.

Because Medicaid eligibility is so narrow, and because payments are inadequate, ~~many~~ the health of thousands of children suffers.

Adequate health care is a right for Michigan's children. If so many thousands are not receiving regular health care, the system isn't working for them.

And health of children affects our future as a state. The future productivity of our children will certainly be hampered by untreated childhood health concerns.

United States Senate

WASHINGTON, D.C. 20510

HEALTH CARE FOR CHILDREN: PROTECTING AMERICA'S FUTURE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In

Name: Ann Spence

Address: 30910 Westwood

Farmington Hills, MI 48331

Representing: Visiting Nurse Association of Southeast Michigan

I invite you to attach a prepared statement or to submit your written

testimony: There is a lack of access by children into
certain sectors of medical care for the following three reasons.

1. Families with limited income and no health insurance can not
afford to pay for any medical expenses whether
routine or complex in nature.

2. Families with medical coverage have limited
access to health care because many health care
providers are unable to accept medicare reimbursement
rates.

3. Children with long term chronic illnesses quickly
exhaust life time insurance benefits and are
thrust into the vicious cycle of requiring medicare
coverage or having no coverage at all.

June 3, 1990

Dear Senator Donald W. Riegle, Jr:

I attended your hearing May 30th, on, Health for Families and the Uninsured. I am very disappointed in your hearing. You should have had a broader-spectrum on your parent panel. I understood there were going to be seven on the panel and then there are only three. You did not have one parent to represent the Mental Health Child and what they go through.

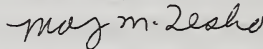
Yes, we do have very serious health Problems in this country in all aspects of life. It is sad and should not be.

You are penalized in the State of Michigan for having a handicapped child that you have no control over having. Why should I be punished.? No insurance for him because he is on the Ritalin Drug. So, I have to go to Medidaid so he can have some coverage, if he should have to go to the hospital. Then, I can't have anything. My other children cannot have a savings account in the bank, no life insurance etc. Just terrible. A cath 22 is what it is. Then you have to air all your laundry out on the line. This is America , and that should not be at all.

Our so called SYSTEM is not geared to help people. We do have a big job ahead of us to get this turned around for our American People. I get tired of our Mental Health Children always getting shoved in the back seat all the time.

I want to thank you for your efforts and I am glad that I did attend the hearing.

Sincerely,



Mary M. Tescho.

Parent/and also work for Association
for Childrens Mental Health.



TOTAL THERAPY MANAGEMENT, INC.

COGNITIVE RESTRUCTURING CENTERS

May 29, 1990

The Honorable Donald W. Riegle, Jr.
Chairman, U.S. Senate Finance Subcommittee
on Health for Families and the Uninsured
Century Center Building, 3rd Floor
30800 Van Dyke
Warren, Michigan 48093

Dear Senator Riegle:

This letter is respectfully submitted as written testimony to the U.S. Senate Finance Subcommittee on Health for Families and the Uninsured.

As a provider of rehabilitation services for traumatically brain injured (TBI) individuals, I am aware of the inequities in the provision of health care for those with little or no insurance. Our Medicaid system does not provide adequate coverage for these individuals, nor does it provide adequate reimbursement to providers for the services it does cover.

The treatment of TBI offers a glaring example of Medicaid's failure, not only for children, but young adults as well. Two-thirds of all persons sustaining head injuries are under age 35, with a life expectancy of 65 to 70. Yet Medicaid does not pay for many types of rehabilitation. Many young persons who could benefit from rehabilitation and vocational services are placed in institutions or require long term care when they could return to productive and self-sufficient lives.

Twenty-five years ago, when Medicare and Medicaid were established, it was assumed that these programs would solve the problem of assuring adequate health care for all citizens. Today, Medicare covers only about 40 percent of the health costs of the aged; states have slashed Medicaid; and 37 million Americans have no insurance, while many more millions have too little insurance. As you reported, some 300,000 children in Michigan alone have no health insurance. For those covered by Medicaid, health care providers have had to subsidize the gap between the cost of providing services and government reimbursement.

In Michigan, Medicaid payments fall well below the costs. Health Care Weekly Review reports that in 1988, the accounting firm Coopers & Lybrand estimated that the state paid approximately 82 cents for every dollar of care delivered to Medicaid recipients. Last year, national health care consultant Hal Cohen, Ph.D., found that payments to Michigan hospitals under Medicaid covered only 79 percent of costs. In 1990, Cohen said, the program paid only 76 cents on the dollar, with more cuts proposed.

Just as health care providers have an obligation to provide quality, efficient, and cost effective care; government has an obligation to fund the cost of providing care that has been promised by government. Providers cannot continue to subsidize Medicaid patients and remain solvent. It is ironic that at a time when the Michigan legislature is considering budget cuts for Michigan Rehabilitation Services and other social service agencies, the legislators are also reviewing proposed changes to our No-Fault Law which will dramatically increase the number of clients such agencies will need to process.

We hope that legislators will vote to adequately fund the Medicaid budget, for all Medicaid recipients, but particularly to assure needed health care for children.

Thank you for your consideration.

Sincerely,

Kay Farnell
Executive Director



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2525 HALL ROAD, MUSKEGON, MI 49442
(616) 773-3448

May 25, 1990

Dear Senator Riegler,

It has been brought to my attention you are concerned about health care for low income families. Could you stand hearing one more story?

I am a single working mother. I work for Love Inc. in Muskegon County. We are a Human Resource Service for area families needing food, clothes, medicine, and shelter. I love my job, the only problem is health care, there is none. I make \$5.25 an hour and I work 37.5 hours per week.

I've been divorced for eight years. During those eight years I was on public assistance. I had medicaid, food stamps, and a grant. Thank God for the medicaid, because Dec. 1985 my daughter was diagnosed with a brain tumor, she died Dec 1987. If I didn't have the medicaid, the medical cost would have been thousands and thousands of dollars. St. Jude hospital paid for most of my daughters care.

Now I am totally off public assistance and trying to raise my son on what I make at Love Inc. I also should mention I live in government housing. When I was on public assistance my rent was \$54.00, now that I am working, my rent is \$196.00. This may not sound like much, but to the working poor it takes away from the food I should be putting on the table.

I don't want you to think I'm feeling sorry for myself, because I feel very lucky to have a healthy son, and a job I love, but we need to have medical insurance for the working poor, and the housing situation needs to have changes made. The cost allowance for housing needs to be adjusted, so we can afford decent housing.

Thank you for taking the time to hear my story. Please be the voice for the working poor americans!

Respectfully,

Diana M. Wright

a facilitating link between needs and resources

